Maternal and Child Health Services
Title V Block Grant

State Narrative for IDAHO

Application for 2007
Annual Report for 2005

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. Public Input

Last year Idaho contracted with Health Systems Research to conduct Idaho's 5 year needs assessment. This process included input from various organizations and individuals representing MCH populations. The process included written and phone surveys, focus groups and key informant interviews. See attached needs assessment. In addition to soliciting comments from the general public, members of the Needs Assessment Advisory Committee were asked to review and comment on this year's application. MCH funded programs involve public input as appropriate for program direction and implementation. For example, CSHP's ongoing effort to transition the program from a pay for service to a systems development and maintenance program. The program has coordinated numerous meetings with policymakers, advocates, health care providers and families to begin designing a system that will assure access to specialty health care for CSHCN. Public input will be solicited as we develop strategies to address the priority areas identified in the needs assessment.

II. Needs Assessment

In application year 2007, the Needs Assessment must be provided as an attachment to this section.

III. State Overview
A. Overview
Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and unhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 40th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.
/2004/ The 2001 estimated population for Idaho is 1,321,006.

/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. /2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//

/2005/ Summary of Population by Region (Health District) for 2000
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 250,984 19.40
District 2 100,533 7.77
District 3 191,297 14.78
District 4 344,355 26.61
District 5 162,397 12.55
District 6 156,906 12.13

District 7 160,132 12.38

/2005/ Summary of Population by Region (Health District) for 2003
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 265,672 19.44
District 2 100,348 7.34
District 3 213,465 15.62
District 4 369,002 27.01
District 5 167,444 12.26
District 6 158,266 11.58
District 7 168,969 12.37

//2005//

/2007/ Summary of Population by Region (Health District) for 2005
(July 1, 2005 Census Estimate)

DISTRICT	***POPULATION***	***PERCENT***
District 1	***201,570***	***14.1%***
District 2	***100,465***	***7.0%***
District 3	***227,825***	***15.9%***
District 4	***389,228***	***27.2%***
District 5	***170,617***	***11.9%***
District 6	***162,342***	***11.4%***
District 7	***177,049***	***12.4%***

//2007//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; 8 native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans reside on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2004/ Racial groups that comprised Idaho's population in 2000 were: (a) white, 91%; (b) black, .4%; (c) American Indian/Alaskan Native, 1.4%; (d) Asian, 0.9%; (e) Native Hawaiian/Pacific Islander, 0.1%; and (f) Other, 4.2%. Hispanics make up 7.9%.

/2007/ Population Estimate, July 1, 2004
Percent of Total Population Estimate in District by Race and Ethnicity

		Race				***Ethnicity***
	Total	***White***	***Black***	***American Indian***	***Asian and Pacific Islander***	***Hispanic or Latino****
Idaho	***100.0%***	***96.4%***	***0.7%***	***1.6%***	***1.3%***	***8.9%***
District 1	***100.0%***	***97.2%***	***0.4%***	***1.9%***	***0.6%***	***2.5%***
District 2	***100.0%***	***94.6%***	***0.5%***	***3.5%***	***1.3%***	***2.1%***
District 3	***100.0%***	***97.0%***	***0.6%***	***1.2%***	***1.1%***	***18.1%***
District 4	***100.0%***	***95.6%***	***1.3%***	***0.9%***	***2.3%***	***5.8%***

District 5	***100.0%***	***97.9%***	***0.5%***	***0.9%***	***0.7%***	***16.7%***
District 6	***100.0%***	***94.7%***	***0.6%***	***3.8%***	***0.9%***	***8.2%***
District 7	***100.0%***	***97.9%***	***0.6%***	***0.7%***	***0.8%***	***8.0%***

****Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.***

Source: National Center for Health Statistics. Estimate of July 1, 2004 resident population from the Vintage0 204 postcensal series by state, county, year, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; Internet release September 9, 2005. //2007//

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. /2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//

Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho ($36,023) was 9.2% lower then the national average ($39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//

Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

/2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//

/2007/ Idaho's 2004-05 dropout rate among 16-19 year olds _____. In 2004, 36.6 percent of people in Idaho 18 to 24 years of age have completed high school (including equivalency). In 2004, 87.3% percent of people 25 years and over in Idaho had completed high school (including equivalency) ranking Idaho 18th.//2007//

Health Delivery System in Idaho

As a frontier state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

/2007/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult CF clinics are held at St. Luke's, and PKU clinics are held quarterly at the state laboratory in Boise and twice annually at two district health departments. //2007//

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. /2005/ Bed capacity has increased to 3,326.//2005//

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

/2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//

/2007/ There are 10 Community and Migrant Health Centers (organizations) in the state, but many of them have satellite clinics. It is perhaps more accurate to say there are 10 Idaho

organizations serving 34 communities (including three communities in Oregon). The 330 grantees aggregately served 88,932 patients in 2005, with 329,228 total encounters (this includes medical, mental health, substance abuse and dental). It also includes 9,255 encounters for "enabling services" (case managers, health educators).//2007//

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 96.

/2006/ As of May 2005, there were 685 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice, General Practice, Obstetrics, Gynecology, Ob-gyn, Pediatrics and General Internal Medicine as their primary specialties.) There were a total of 308 Physician Assistants, 29 Certified Nurse Midwives, 441 Nurse Practitioners and 1,073 Pharmacists licensed and practicing in the state. It is also practical to note that there are 254 licensed Community Pharmacies in Idaho. There were 810 Physical Therapists, 297 Occupational Therapists (and 98 Occupational Therapy Assistants), 57 Psychiatrists and 687 Dentists licensed and serving Idahoans. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2006//

/2007/ As of May 2006, there were 1,170 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 592, General Practice 31, Ob-gyn 140, Pediatrics 131 and General Internal Medicine 276 as their primary specialties.) There were a total of 352 Physician Assistants, 21 Certified Nurse Midwives and 289 Nurse Practitioners There are approximately 1,700 Pharmacists licensed with the State of Idaho, 1400 of whom are practicing in the state. It is also practical to note that there are approximately 250 licensed Community Pharmacies in Idaho. There were 846 Physical Therapists, 316 Occupational Therapists (and 98 Occupational Therapy Assistants), 96 Psychiatrists and 716 General Dentists licensed and serving Idahoans, and 884 total licensed Dentists in Idaho. There are 882 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2007//

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance;

however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

/2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, compared to 12.6% of the U.S. population enrolled in Medicaid. Additionally, the 1998 Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

/2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS systems that often serve as first encounter points for direct care. Poverty level and low-income populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//

/2006/ Currently, 88.4% of the state's area has a designation as a health professional shortage area in primary care, 88.7% in dental health, and 100% in mental health (Figures 1, 2 and 3). //2006//

/2007/ According to the Morgan Quitno Press, Health Care State Rankings 2006, Idaho ranked 50th for "rate of physicians in 2004" with 193 per 100,000 population. Idaho ranked 49% for "rate of physicians in patient care in 2004" with 161 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2005" with a reported 17.9%. Currently, 90.0% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.9% in Dental Health, and 100% in Mental Health.//2007//

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

/2007/ According to the July 2005 population estimates, U.S. Census Bureau, the

population of Camas County is now 1,050 and the population of Clark County is 943. Camas County now has services in Fairfield. Clark County does not have services.//2007//

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/migrant clinics in north Idaho.

/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//

/2007/ The Bureau of Facility Standards lists 47 certified rural health clinics. There are nine free medical clinics registered with the State of Idaho.//2007//

/2005/During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care on-site has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 on-site community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//

Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

/2007/During SFY 2005, there were 104,041 children enrolled in Title XIX Medicaid for at least one month of the year and another 12,458 children enrolled in the Medicaid expansion Title XXI CHIP A and CHIP B.//2007//

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000 through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

/2007/ During SFY 2005, the toll-free Idaho CareLine averaged 331 calls per month from persons seeking a Medicaid dentist, down 27 percent from 2005. Calls totaled 3,969 seeking a Medicaid dentist and 741 persons seeking free or reduced dental services. A total of 567 dentists (64%) of 884 dentists with an Idaho license and in-state address had one or more paid Medicaid claims and 325 (57%) of Medicaid billing providers had paid claims of $10,000 or more. Five Idaho counties are without a dentist and 11 counties have

no Medicaid billing dentist who saw 50 or more beneficiaries under age 21.//2007//

/2006/ During SFY 2004, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist, up 86 percent from 2003. Calls totaled 5,459 seeking a Medicaid dentist and 602 persons seeking free or reduced dental services.//2006//

/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/ Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

/2006/ During SFY 2004, the average monthly enrollment of eligible children in Title XIX Medicaid was 100,520 and 11,235 in Title XXI CHIP.//2006//

/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5 years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving $10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically call each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

/2005/During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > $10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area.
//2005//

/2006/ As of July 2004, there were 807 active licensed dentists with Idaho addresses; 563

(69.8%) dentists had at least one paid Medicaid claim and 319 (39.5%) had paid claims > $10,000, a substantial increase over 2003. Four of the 44 counties had no enrolled Medicaid dentist. //2006//

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program (CSHP). We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

/2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long-term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and

Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's previous Governor declared this the "Generation of the Child", and in doing so, established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2003/ The number of providers providing vaccination data to IRIS increased to 100. To date there are over 139,814 patient records.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18.//2005//

/2006/ As of 6/10/05: 253 Health Care Providers, 758 Schools and Daycares are enrolled in IRIS. 265,228 patients total, 3,124,787 vaccinations. 190,712 records are 18 and younger, 74,516 are

over 18.//2006//

/2007/ As of 05/29/06: 276 Health Care Providers, 903 Schools and Daycares are enrolled in IRIS in Idaho and 7 providers from border areas in Washington State are also enrolled. 297,554 patients total, 3,739,209 vaccinations. 290,734 records are 18 and younger, 85,422 are over 18. 93% of all Idaho newborns are consented into the Idaho Immunization Registry. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2007//

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to provide leadership for development and implementation of a sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

/2005/ The Any Door Initiative has been piloted in one small office in Health District 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in accessing public health services even though they are applying through a social service center.//2005//

/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.

Another project that is included in the FFY '05 budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended

by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.

And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs. //2005//

/2006/ Idaho is initiating a project to improve access to prenatal dental care, targeting low income women during their second trimester. This project will seek to achieve two goals, first is to increase referrals by obstetric providers, second to increase the number of pregnant women that actually receive dental services during pregnancy. //2006//

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical

Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred directly.

The Newborn Screening Program recently expanded newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia.//2005//

Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

Infant mortality and low birth weight
Adolescent pregnancy
Vaccine preventable diseases
Injuries
Substance and physical abuse
Investigation and control of "clusters" of reportable diseases and conditions
Prenatal care utilization
Children's access to health care coverage
Risky behavior in adolescents
Increased data capacity

An attachment is included in this section.

B. Agency Capacity

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9). /2006/ Bureau of Health Promotion is now the Bureau of Community and Environmental Health. //2006//

/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Womens Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health.//2005//

/2006/ A new program was added to the Bureau of Clinical and Preventive Services to support the Division of Health's information technology programs including WIC's data base, the Immunization Registry, Health Alert Network, and the National Electronic Disease Surveillance System. This program's primary function is a help desk and to also assist with managing system upgrades and maintenance. //2006//

/2007/ With the resignation of the Health Systems Support program manager in February 2006, and the retirement of one of the employees in April, the management of the IT help desk staff was placed back in the programs, WIC, Immunizations and Office of Epidemiology and Food protection. //2007//

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2007/ The Child Mortality Review Team was disbanded in 2003. Idaho is aggressively overhauling the EMS patient care reporting system and implementing a trauma registry for hospitals to report on severely injured patients to counterpose against mortality data. The published reports of the CMRT showed that injury was the prevailing issue. //2007//

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse that are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this collaborative effort.

/2007/ Due to waning attendance, the quarterly MCH meetings were disbanded in 2005. We are trying a new approach of monthly meetings with the Bureau Chiefs of Clinical and Preventive Services, Community and Environmental Health and a representative from the Division of Medicaid. This planning should identify and support opportunities for program integration and enhancement. Others will be brought to the table as is appropriate. //2007//

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission related to maternal and child health fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), and biotinidase deficiency, in addition to PKU.

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

/2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//

/2007/ Cystic fibrosis will be added to the newborn screening program in the fall of 2006. //2007//

Children's Special Health Program.

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

/2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//

/2006/ CSHP rules were revised during the 2005 legislative session. The most significant change was to change eligibility criteria. Previously the program was open to children meeting certain diagnostic criteria regardless of insurance status. The rules have been revised to limit program services to uninsured children only. //2006//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

/2003/ Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

/2007/ Russell Duke, M.S., resigned as Bureau Chief of the Bureau of Clinical and Preventive Services in October 2005. In December 2005, Ms. Dieuwke A. Spencer, R.N., M.H.S. was hired as Bureau Chief. Prior to this position, Ms. Spencer was the Section Manager for Chronic Disease in the Bureau of Community and Environmental Health for a

year and previously the Supervisor for the Office of Epidemiology and Surveillance at Central District Health Department in Boise, Idaho, where she had been employed for 14 years. //2007//

Susan E. Ault, B.S.N., R.N., A.R.N.P., has been the Family Planning Program Manager since 1988. This program has been re-named the Reproductive Health Program. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

/2006/ Susan Ault has resigned her position and will be working with the Idaho Primary care Association. Her position is presently open for new applicants.//2006//

/2007/ Anne Williamson retired in December 2005 as the STD/HIV Program Manager. Jesus Sandoval, M.S.W. was hired in April 2006 as the Reproductive Health Program Manager. Mr. Sandoval has administrative oversight of the Title X program as well as the STD/AIDS programs. //2007//

Christine Hahn, M.D., has been the State Epidemiologist since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiological support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

/2004/ Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

Leslie Tengelsen, Ph.D., D.V.M., has been the Assistant State Epidemiologist since 1998. She also provides epidemiological support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

/2007/ Dr. Tengelsen's support levels remain the same, funding is at 0.5 of her salary. //2007//

/2003/ Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

/2005/ Jared Bartschi, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//

/2007/ Mr. Bartschi is funded at 0.25 FTE through the MCH block grant. //2007//

/2007/ Merideth Duran, Technical Records Specialist with the Office of Epidemiology and Food Protection, is funded 0.25 FTE through the MCH block grant. Ms. Duran provides support for the e-HARS computer system. //2007//

/2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//

Judy Peterson, M.S., R.D., L.D., provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho

WIC Program.

/2004/ Judy Peterson resigned in July of 2002 but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical Center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions.

/2006/ Emily Geary transferred from the WIC program to the Breast and Cervical Cancer Screening Program. Jean Heinz was hired in her place. Ms. Heinz has over 20 years of experience as a Registered Dietitian and most recently worked for the Idaho State Department of Education, Child Nutrition Programs.//2006//

/2007/ In January, 2005, Katie Bagley, RD, LD, was hired in a part-time position to provide dietary and nutritional information to Idaho PKU patients and families. Katie's first several months in the position resulted in quantifiable increases in formula usage by patients, greater patient compliance with monthly phe level blood tests, and positive feedback from families concerning her involvement with and commitment to the health and wellbeing of their children. //2007//

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

/2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger, R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//

/2006/ Linda Morton has resigned from the Department of Health and Welfare. Cristi Litzsinger was hired in her place. Ms. Litzsinger has 8 years experience working in WIC and is an Internationally Board Certified Lactation Specialist.//2006//

Christina Giso, M.B.A., is Idaho's current MCH State Systems Manager (formerly designated the State Systems Development Initiative Coordinator) and the new Genetic Services Program Coordinator. Her advanced degree is in health systems administration, and her primary focus has been the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

Bureau of Health Promotion

/2005/ Name changed to the Bureau of Community and Environmental Health.//2005//

Ginger Franks, Dr.P.H., has been the Injury Prevention Program Manager since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

/2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on preventing falls and transitioning the child car safety seat program to other partners.

Kaili McCray has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.//2004//

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.//

/2006/The Adolescent Pregnancy Program has been transferred to the Governor's Office.//2006//

Lisa Penny, B.S., R.D.H., has been Oral Health Program Coordinator since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for

areas of medical under service, barriers in access to health care, and identification of health disparities.

Bureau of Health Policy and Vital Statistics

Dianna Willis, M.A., has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP) and will soon be the MCH State Systems Manager.

/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.

/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.

/2006/ Dianna Willis recently resigned and the position is currently open for new applicants. //2006//

/2007/ Teneale Chapton, M.S., has been the Perinatal Research Analyst (a.k.a. Principal Research Analyst) since July 2005. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Teneale Chapton is the current SSDI Program Manager for Idaho, as well as a member of the Association of Maternal and Child Health Programs (AMCHP) and serves on the Advisory Board for the Idaho Perinatal Project. //2007//

/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing who is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.

/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

/2007/ Patricia Williams is the Idaho CareLine Program Supervisor. //2007//
Public Health Districts

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the masters level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State

General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

C. Organizational Structure

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group follows.

Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women, and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing at St. Luke's Children's Hospital.//2005//

Children

/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho.//2005//

/2007/ The Bureau of Community and Environmental Health received funding for Comprehensive Cancer planning. //2007//

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

/2007/ Adolescent Pregnancy Prevention has been transferred to the Governor's Office.//2007//

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on college campuses.//2005//

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners.//2005//

/2007/ The Injury Prevention Program has transitioned successfully child safety seat distribution and installation and education to state and community partners. The program is currently focusing on fall prevention for the elderly. //2007//

Children with Special Health Care Needs.

The Children's Special Health Program (CSHP) provides and promotes direct health care

services in the form of family centered, community-based, coordinated care for children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics.//2005//

All MCH Populations

The State Epidemiologist provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the Deputy State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCHB EMSC grant.

/2007/ The State Epidemiologist and the Deputy State Epidemiologist provide health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population.//2007//

The STD/AIDS Program provides HIV prevention education activities, as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

/2007/ Jared Bartschi oversees contractual performance of the district health departments related to STD and HIV investigations and performs analysis of epidemiologic data. Merideth Duran is involved with the different aspects of data management, including activities to assure data quality and data entry.//2007//

The toll-free telephone referral service, Idaho CareLine, provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

/2006/ The Idaho CareLine has been designated the 211 Call Center for Idaho. Callers can now access referrals for any health and human service issue by dialing 211 or 1-800-926-2588. //2006//

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

An attachment is included in this section.

D. Other MCH Capacity

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

A 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist staff the CSHP program. In addition, services for PKU and high-risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.2 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

/2006/ The CSHP Manager is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinate genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.//2006//

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

/2006/ The CareLine is now supported by a 1.0 FTE Community Services Coordinator and 6.5 FTE Customer Service Representatives.//2006//

/2007/ The CareLine is supported by a 1.0 FTE Program Supervisor and 9.0 FTE Customer Service Representatives.//2007//

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion, programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

/2006/ The child mortality team has been disbanded. //2006//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

/2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//

In addition to having funding ties to MCH programs, there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

/2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//

/2006/ The Adolescent Pregnancy Prevention program is now with the Office of the Governor.//2006//

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments has very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

E. State Agency Coordination

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. These agreements refer to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V

(Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

/2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.

/2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//

/2006/ During FY 2004, legislation changing the Idaho State Dental Practice Act was enacted, creating an extended access endorsement for dental hygienists allowing preventive dental hygiene services to be provided under general supervision in public health settings and allowing retired dentists to provide clinical dental services on a volunteer basis in non-profit dental clinics. Medicaid analyzed the potential cost impact if direct reimbursement were allowed to extended access endorsed dental hygienists. Currently, only district health departments or other entities that employ a dental hygienist can receive Medicaid reimbursement./2006/

/2007/ During FY 2005, Idaho was one of 13 states selected to send a team to the CHCS Purchasing Institute Best Practices for Oral Health Access, held in Philadelphia in September 2005. The MCH Oral Health Program worked with the Division of Medicaid to develop the Idaho application. Information gained at the CHCS Purchasing Institute was timely and useful in developing the oral health component of the proposed Idaho Medicaid Modernization, which emphasizes prevention and disease management.//2007//

/2006/ Women's Health Check cooperates with the Divisions of Medicaid and Welfare to provide treatment for women diagnosed with breast or cervical cancer.//2006//

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. These two federal programs jointly fund the Reproductive Health Program. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient

collaboration with the Bureau of Health Promotion, with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, oral health promotion, diabetes control, arthritis, and rape prevention. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho CareLine. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:
a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
f) Healthy Child Community, an interdepartmental group interested in promoting the health and well being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
h) Idaho Breast and Cervical Cancer Alliance (IBCCA), dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. /2005/ This group is no longer a functioning partnership. //2005//
l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI

approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
n) Idaho Governor's Council on Adolescent Pregnancy Prevention.
o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho, with recommendations for preventing future child deaths. /2006/ This group is no longer active.//2006//
/2004/
r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding, volunteer networking and operation of the community health center dental clinics. /2006/ Committee no longer meets./2006/
s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho. ***/2007/ With the establishment of the Idaho Physical Activity and Nutrition Program, this committee no longer meets. Most participants now partner with the IPAN program.//2007//***
w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.
x) Friends of Children and Families Head Start Health Advisory Committee. /2006/
y) Association of State and Territorial Dental Directors Data Surveillance Committee. /2006/

Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the public health districts. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Bureau of Health Policy and Vital Statistics, has a

cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide immunization status assessments of their clinics, as well as identifying barriers to immunization.

/2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//

/2006/ The MOU between Family Health Services and the Idaho Reproductive Health Program is currently in place until January 2006 when progress will be re-evaluated. Success of this partnership has been demonstrated by the 717 clients seen in CY04. In the first quarter of CY05, Family Health Services reported 421 clients have been seen in their clinics for reproductive health care. Eighty-two (82) percent of these clients reported incomes of less than 100 percent of the federal poverty level. An MOU is also in place between Southeastern District Health and Healthwest, a community health center, in Pocatello, Lava Hot Springs, and Downey, Idaho. Clinics in Lava Hots Springs and Downey serve an area with limited pharmaceutical services.//2006//

Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho and a survey of medical providers for the Office of Primary Care by Boise State University. The State Epidemiologist collaborated with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university has also been a contractor with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium. Currently, the Immunization Program is contracting with Boise State University and Idaho State University to provide student interns to private immunization providers to assist with the implementation of patient reminder/recall systems for their immunization patients.

/2005/ The Immunization Program no longer contracts with these universities as this program is already implemented.//2005//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *Number of resident asthma (ICD-9 codes: 493.0 - 493.9) hospital discharges for children less than five years old.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	21.4	26.1	28.0	28.0	20.0
Numerator	99	129	145	153	111
Denominator	46164	49406	51875	54629	55482
Is the Data Provisional or Final?				Final	Final

Notes - 2003

Medicaid data only.

Narrative:
Idaho does not have hospital discharge data available, so we do not know the discharge rate for children or adults.

In an attempt to address the known contributors to hospitalizations among children (lack of knowledge among care providers, lack of access to medications during school hours, environmental triggers, and inappropriate diagnosis and treatment), the Idaho Respiratory Health Program (formerly known as the Idaho Asthma Prevention and Control Program) and its partners, American Lung Association, Idaho Department of Education, and School Nurses Organization of Idaho, are working with schools to increase awareness among and efficacy of school staff, and has developed the School Asthma Management Model for Idaho (SAMMI) that was distributed to all schools in Idaho. SAMMI is an administrative, policy, and educational tool. The Respiratory Health Program and its partners successfully passed legislation to allow children to carry their asthma inhalers and self-medicate while at school. The Respiratory Health Program and the American Lung Association are partnering to provide the Open Airways for Schools program statewide, and the Respiratory Health Program and the Indoor Environment Program are providing Tools for Schools assessments statewide. Over 250 child care providers have been educated in the management of asthma, and approximately 50 health care providers statewide have been trained in the appropriate diagnosis and treatment of asthma. Additionally, the Respiratory Health Program has trained over 300 Head Start staff and 200 Head Start parents in methods to decrease exposures to asthma triggers in the home.

We will continue to educate health care providers through an Asthma Educator Institute with the American Lung Association Washington.

While there is no way to know what impact these interventions may be having on hospitalization rates for children, they are all based on best practices and can be assumed to have some level of effect.

Health Systems Capacity Indicator 02: *Number of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	69.6	69.5	70.5	72.6	2.4
Numerator	14162	14804	15706	16985	574
Denominator	20361	21296	22276	23406	23865
Is the Data Provisional or Final?				Final	Final

Notes - 2003
Data not available prior to 2001.

Narrative:
The Division of Medicaid is continuing to work on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

Health Systems Capacity Indicator 03: *Number of SCHIP enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	47.8	54.0	42.9	42.0	1.3
Numerator	300	302	210	235	222
Denominator	627	559	490	559	16834
Is the Data Provisional or Final?				Final	Final

Notes - 2003
Data prior to 2001 not available.

Narrative:
The Division of Medicaid continues to work on a project that educates parents and providers regarding well baby clinics. reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

Health Systems Capacity Indicator 04: *Number of women (15 through 44) during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	74.6	75.6	76.8	74.2	
Numerator	14147	15187	15955	15814	
Denominator	18968	20092	20777	21314	
Is the Data Provisional or Final?				Final	

Notes - 2005
2005 data not available until September 2006.

Notes - 2004
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2003
Data are for Idaho resident births and are based on records with known data for calculating the index.

Narrative:
Data are for Idaho resident births and are based on records with known data for calculating the Index.

Health Systems Capacity Indicator 07A: *Number of children 1 to 21 years of age who have received a service paid by Medicaid during the federal fiscal year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	87.1	89.5	94.3	92.5	87.1
Numerator	113555	127524	142394	150105	128422
Denominator	130313	142425	151017	162240	147366

Is the Data Provisional or Final?				Final	Final

Notes - 2003
Data not available for 2003.

Narrative:
Available and included.

Health Systems Capacity Indicator 07B: *Total EPSDT eligible children aged 6 through 9 receiving any dental services in the reporting period.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	44.2	45.3	48.0	49.2	51.0
Numerator	10138	11265	14952	16759	15345
Denominator	22918	24864	31177	34068	30069
Is the Data Provisional or Final?				Final	Final

Narrative:
Medicaid is reimbursing doctors and midlevel providers for topical fluoride applications.

Health Systems Capacity Indicator 08: *The number of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State's CSHCN program during the Federal fiscal year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	2873	2726	3077	1949	3244
Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Healthy & Ready to Work website:
www.hrtw.org

Notes - 2004
All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. Medicaid, rather than Title V, pays for all necessary rehabilitation services.

Notes - 2003
All youngsters who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. Medicaid, rather than Title V, pays for all rehabilitation services.

Narrative:
Always 0 since CSHP only provides insurance coverage equivalent for children with no source of payment.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2004	payment source from birth certificate	7.9	6	6.8

Narrative:
Available and included.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	payment source from birth certificate	6.5	5	6.2

Narrative:
Available and included.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	payment source from birth certificate	61.5	77.8	71.9

Narrative:
Available and included.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2004	payment source from birth certificate	66.7	78.5	74.2

Narrative:
Available and included.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2005	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	150

Narrative:
Available and included.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children	2005	
(Age range 1 to 5)		133
(Age range 6 to 18)		133
(Age range 19 to 19)		100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2005	
(Age range 1 to 2)		150
(Age range 2 to 3)		150
(Age range 3 to 19)		150

Narrative:

Available and included.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	133

Narrative:
Available and included.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like	3	Yes

PRAMS)		

Notes - 2007

Narrative:
Described on form 19.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2007

Narrative:
Described on form 19.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted five years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

/2006/ Idaho has just completed its 5 year needs assessment. A contractor, Health Systems Resarch, performed the needs assessment. The assessment included several meetings with key stakeholders, key informant interviews, focus groups, general and population specific surveys, review of secondary data and a capacity assessment among state level MCH personnel. Priority needs are listed in the next section. //2006//

B. State Priorities

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.
4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children, and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

/2006/ Below is a list of priority areas that were identified during Idaho's 5 year MCH needs assessment. They are not in order of priority, but rather a list of the 10 key areas needing attention.

Priorities:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.

2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.

3. EPSDT screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring as appropriate for all infants, children and adolescents.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex care needs of all CSHCN.

6. Cultural Competency: Improve cultural competency across all programs that work with the Maternal and Child Health population.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including developing strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing system collaboration efforts that

focus on defined outcomes for the MCH population. Start building the infrastructure within MCH programs to sustain efforts over time, and work to include all MCH partners when planning and targeting efforts.

10. Overweight and obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children. //2006//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			100	100	100
Annual Indicator	99.3	97.3	95.0	100.0	100.0
Numerator	20537	20404	19	16	28
Denominator	20686	20965	20	16	28
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2003
In 2003 one child had a mild form of a condition and needed no treatment; for one child the date of treatment initiation is unknown.

a. Last Year's Accomplishments
Idaho contracts with the Oregon Public Health Laboratory for screening and consultative services, and the most troublesome statistic concerning Idaho's screening program was the error rate of specimens submitted that took more than five days to reach the laboratory. It was the program's highest priority this year to reduce that error rate. The Idaho program manager and a nurse educator from Oregon Health and Science University (OHSU) attended the 10th annual nurse manager's summit meeting last fall and made a newborn screening presentation to the more than 30 nurse managers in attendance from medical facilities around the state. Tandem mass spectrometry technology was explained, along with the importance of the timely mailing of test kits to the Oregon laboratory. This followed visits by newborn screening staff to 33 birthing facilities in all parts of the state, during which each facility's practice profile was discussed and copies of the Idaho Practitioner's Manual were provided. Instructional videotapes featuring proper specimen collection were purchased and provided free-of-charge to the twenty largest facilities and the state's largest medical center's lending library. The transit error rate for Idaho has been reduced from a high of 41% in January of 2004 to 6% in March of 2005.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide education/technical assistance to birthing facilities and midwives in all regions of the state.		X	X	X
2. Implement and utilize telemedicine visits for Idaho families with Oregon metabolic consultants	X	X	X	X
3. Add Cystic Fibrosis screening to MS/MS test battery	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provider education has remained a priority this year. Birthing centers across the state are continuing to be visited annually, and monthly practice profiles are distributed to providers. Cystic Fibrosis will be added to the MS/MS test battery this November, making Idaho the first state of those contracting with Oregon to do so.

The regional cooperative grant has funded this year the part-time staff position that handles test kit ordering and follow-up with birthing institutions, a day-long educational session on PKU for health district nutritionists, the development of personalized PKU food plans and clinical services by Oregon geneticists, a new parent brochure explaining the need for metabolic screening, and three telehealth visits from St. Luke's Regional Medical Center to Oregon Health and Science University.

Confirmed positives are referred immediately to the state genetics program for follow-up by a genetics counsler, who, when appropriate, schedules families to be seen in clinics staffed by metabolic consultants from Oregon Health and Science University.

c. Plan for the Coming Year

Provider education will continue to be a priority for the newborn screening program. The regional cooperative grant has been renewed, and it is anticipated that ongoing education and the increased use of telemedicine will be the focus for the program this coming year.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective			60	60	60
Annual Indicator		57.2	57.2	57.2	57.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	60	60	60	60	60

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with advocacy organizations to provide technical assistance and funding support.		X		X
2. Work with Medicaid Health Connections staff to encourage simplifying existing program policies for special needs families.	X	X		X
3. Fund community surveys to identify insured special needs families in order to ensure their connection with advocacy and support organizations.		X		X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The SLAITS survey indicated that 57.2% of families in Idaho partnered in decision making at all levels and were satisfied with the services they receive. A May, 2002, statewide family survey, conducted as part of developmental pediatrician Dr. Nancy Mann's CATCH grant, indicated that 84.5% of families surveyed participated in decision making for their child's care and that 60% were satisfied with services received. It is important to note that families surveyed were, at the time, actively receiving care coordination services from CSHP.

Focus group discussions for Idaho's five year needs assessment supported MCHB Chartbook data that indicated a higher percentage of families with Medicaid reported problems obtaining specialty care for their children. Healthy Connections, Idaho's Medicaid managed care program, adds a step in obtaining care that requires parents to visit their primary care provider to obtain a referral to a specialist. CSHP had hoped to meet and work with Medicaid staff this year to address this issue, but the Division of Medicaid is involved with an extensive reorganization, and the upheaval of that process has prohibited any progress with those efforts. It remains a future goal.

CSHP, through a Champions for Progress grant and additional funding from the program to underwrite participant travel and lodging, sponsored four Idaho parents to attend the October Family Voices regional conference. Those parents have become active in the first steps of establishing a statewide network of parent meetings, workshops and mentors for families with special needs children. Idaho was a recipient of a Family 2 Family grant, and CSHP is providing funding to assist with the development and stability of that center, which is housed at Idaho Parents Unlimited (IPUL), a parental support organization which is also receiving CSHP funding to help sponsor its annual conference.

c. Plan for the Coming Year

The decision in 2004 to provide CSHP enrollment to only uninsured children who meet the program's nine diagnostic criteria have reduced program numbers from over 3000 to just over 300. Transitioning the program from a clinic and direct services orientation to one with a more comprehensive intrastructure-building focus will be a years-long process. Federal estimates indicate a possible total of some 16,000 special needs youngsters in Idaho, and an ongoing challenge to the program will be devising ways to identify these children and families. Funds will be earmarked to provide statewide community-level surveys and other needs assessment techniques in an attempt to locate and identify such families, with the intent of ensuring that they are directed toward services that can meet complex medical needs and are connected with advocacy and support organizations.

A continuing effort to strengthen existing relationships with Idaho advocacy organizations will proceed this coming year, with the goal of making it clear, through policy and action, to all relevant constituencies that CSHP is programatically and financially committed to working in partnership with families, providers and other agencies/programs.

Work will also continue on the other activities described in the Current Activities section.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			50	52	52
Annual Indicator		49.1	49.1	49.1	49.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52	52	52	52	52

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Pursue development and implementation of "medical summaries" for use by special needs families and providers.	X	X		X
2. Utilize existing linkages with state AAP and AAFP chapters to address the medical home concept through their organizations.		X		X
3. Explore utilizing medical home training materials developed through an AAP CATCH grant to educate Family Practice physicians.		X		X

4. Explore utilizing the AAP Mentorship Network to provide technical assistance, training and distribution of materials to physician providers.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The medical home concept remains largely unknown or misunderstood in Idaho by providers and families, and significant education needs to take place with both of those groups.

A survey in conjunction with Idaho's five year needs assessment of just over 100 families with children being served by CSHP at the time of the survey indicated that 85% of the respondents felt it was very important to have someone who can coordinate communication between physicians, hospitals and therapists. Data supports that families are explicit about the importance of this area, and given the shortcomings of the medical community in addressing that importance, it remains clear that system-wide efforts are needed to strengthen communication and coordination.

Linkages are in place with the directors of Idaho's AAP and AAFP chapters, and they have both indicated an interest in and willingness to participate in new educational efforts to address the medical home concept through their organizations. The AAP state director will attempt to get medical home education placed on the chapter's priority list of activities for this next year, and is working with incoming officers to move in that direction. Dr. Nancy Mann, a developmental pediatrician at Idaho State University, developed a medical home training for family practice physicians as part of an AAP CATCH grant, and, as family practice doctors outnumber pediatricians four to one in Idaho, this will be an important constituency to include in education efforts. As part of CSHP's attempt to move the program down the MCH pyramid toward more infrastructure-building activity, the tools developed by Dr. Mann will be reviewed to determine which would be most appropriate for inclusion with statewide provider information and education activities.

c. Plan for the Coming Year
Existing relationships with the directors of Idaho's AAP and AAFP chapters have resulted in an interest in and willingness to participate in educational efforts to address the medical home concept through their organizations. Officers of the Idaho chapter of the AAP have identified medical home education as one of their top five priorities for this year. CSHP has earmarked funds to purchase AAP materials on medical home and early intervention and is working actively with Idaho's Part C program to distribute these materials to providers and parents.

As staff time is available, the development and use of "medical summaries" for special needs youngsters will also be investigated. The basic idea of this approach is taking all of the critical medical information for a child that is usually scattered throughout often multiple medical charts

and placing it into an easy-to-read one page, front and back, document. The summary can then be used by families and physicians to communicate more effectively with other medical and non-medical providers who may not be aware of the many unique needs of a particular child. With a medical summary in hand, a family does not have to repeatedly recite an often lengthy medical history to each provider. The summary can also save subspecialist physicians valuable time by eliminating the need to pull vital information from charts or replicating costly and time-consuming tests before treatment.

As mentioned previously, tools developed by Dr. Mann will be reviewed to determine which would be most appropriate for inclusion with statewide provider information and education activities.

It remains a goal to utilize the AAP Mentorship Network to provide additional technical assistance, training and distribution of medical home materials to providers. Attempts to identify, recruit and train individual in-state providers to undertake one-on-one communication with their private practice colleagues will accompany this effort.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective				60	60
Annual Indicator		53.3	53.3	53.3	53.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	60	60	60	60	60

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in

the "Plan for the Coming Year" narrative of this year's application.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue attempts to work with Medicaid staff concerning publicizing and successfully enrolling eligible families in the Katie Beckett program.		X		X
2. Enlist CSHP Summit particpants in efforts to identify options for uninsured and underinsured special needs families.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

National SLAITS data revealed that 53.3% of the families surveyed in Idaho indicated that they had adequate health insurance for their special needs child or children. When insured children were enrolled in CSHP prior to October, 2004, the most common problem for them was the exclusion of certain necessary medical equipment or procedures or simply being "underinsured" relative to the intensity of care needed.

Significant differences continue to exist between public and private insurance coverage in Idaho. Medicaid expenditures, as in many states, are under regular and increasingly intense scrutiny by legislators. This year, as the possibility of exploring a Medicaid carve out for special needs youngsters was suggested by CSHP, Idaho legislators involved in those discussions did not hesitate to explain that legislative leadership had served notice that no expansion to the Medicaid budget would be allowed. That information stalled further discussion of the matter.

In an attempt to look at other possible options, a series of special needs "summit" meetings were scheduled, and a wide variety of invitees to those meetings, who include representatives from the "Blues," providers, families and advocacy organizations, will begin that process. Medicaid's reorganization, still in process at the time of this writing, will also open previously closed doors to explore a variety of opportunities not possible prior to that new approach. CSHP is partnering with state advocacy organizations to ensure that every possibility for covering the special needs population is put before Medicaid leadership.

c. Plan for the Coming Year

The survey of Idaho families as part of Idaho's five year needs assessment indicated that while there are numerous positive aspects of Medicaid coverage for special needs children, there are also numerous challenges that families face in accessing and using Medicaid. One of the most significant of these involves the difficulty families have in finding out about, applying for, and maintaining benefits in the Katie Beckett program. Parents reported that many Medicaid eligibility

workers were unaware of the rules for Katie Beckett and were unable to assist them with applying. This has been an ongoing problem in Idaho, and it is hoped that CSHP staff will be able to initiate meetings with Medicaid policy staff to explain the issue and begin the process of exploring possible remedies.

CSHP also will work to be a catalyst pertaining to insurance issues through partnering with families and advocacy groups to explore alternative sources of medical insurance for special needs children. One important resource mentioned in last year's narrative involves the Health Insurance Guidebook developed in Wisconsin by ABC for Health. Discussion with the group will continue to explore the possibility of developing an Idaho-specific version of the Guidebook.

CSHP involvement with and support of the new Family 2 Family project housed at Idaho Parents Unlimited will hope to enlist existing and developing databases to identify insured and underinsured families throughout the state and ascertain their present circumstances in terms of finding and financing medical care for their special needs children. Funds have been earmarked to assist with the development of an F2F statewide database and the purchase of informational materials for families.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			77	80	80
Annual Indicator		75.2	75.2	75.2	75.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	80	80

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily

been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with public and private insurers to provide training and information to care coordinators about the complexities of special needs children.	X	X		X
2. Utilize and build upon existing relationships with advocacy and support organizations to provide educational and information materials through meetings, conferences and newletters.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SLAITS data indicated that 75.2% of Idaho families felt that special needs service systems were organized so they could use them easily. At the time of the SLAITS survey, most families contacted were enrolled in CSHP, and the program, through its health department care coordination contractors, helped families navigate systems of care across the state. That component remains in place for the uninsured children now enrolled in the program, but families with insurance face new challenges without CSHP involvement.

Focus groups with CSHCN families held as part of the five year needs assessment revealed that many parents with insurance who were no longer enrolled in CSHP reported a significant lack of coordinated services. Parents reported that it was difficult to find updated information about programs, services and eligibility for other resources. Even during the focus groups, families were updating each other about changes in programs and suggesting ways to find information and services.

The needs assessment provided additional confirmation that Idaho's Medicaid care coordination system leaves much to be desired when it comes to assisting children with complex medical issues. Focus group participants expressed a clear need for care coordination services, but reported very mixed experiences with individual Medicaid care coordinators. Parents were confused about just what services these care coordinators were supposed to provide, and some reported that they did not find coordinators' advice useful, did not find them respectful, so they stopped using their services. Parents who participated in focus groups were also worried that while medical care was still available to their children, support services were more likely to be limited and the lack of experience of care coordinators with complex medical issues would be

problematic. Such anecdotal information only serves to verify the need for CSHP to provide technical assistance, training and education to contracted Medicaid care coordinators, and that goal, as previously referred to in performance measure 04, will be high on CSHP's priority list this coming year.

As reported in last year's narrative, discussion has already occurred with the leadership of Family Voices and Idaho Parents Unlimited (IPUL) to include information about this issue with the other initiatives CSHP hopes to undertake with them this coming year. Family Voices and IPUL have agreed to assist CSHP with identifying community individuals and groups that are already involved with families in various ways, and those local contacts will strengthen efforts to address this issue. CSHP will continue to build upon an existing and positive relationship with Idaho's early intervention program, and will provide educational and information materials for that program's newsletters and conferences.

c. Plan for the Coming Year
As CSHP continues to move its focus to infrastructure development from the provision of direct services, work will continue this next year in all areas already identified.

As Idaho's Medicaid program finalizes its reorganization in the coming months, it is hoped that opportunities to expand and strengthen strategies identified above will also provide a roadmap for new activities. CSHP will be able to bring both financial and technical resources to this important challenge. Idaho Blue Cross has also indicated an interest in addressing shortcomings, from a family perspective, in its care coordination activities and CSHP will join advocacy organizations in those discussions with Blue Cross.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			6	6	6
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	6	6	6

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments

The unexpected and long term intensity of reaction to, and the variety of issues arising from, transitioning CSHP this year from a clinically driven direct services program to one focusing on systems and infrastructure development have resulted in state staff, as of this writing, remaining involved primarily with completing the transition process and responding during this past legislative session to media, legislative and advocacy organization requests for information and data.

This has meant that most "Plan for the Coming Year" narrative sections for performance measures 02 through 06 in last year's grant application remain in place but have necessarily been delayed a year. They continue to be priority goals for the program and staff is just beginning to take the initial steps necessary to their realization. The needs assessment conducted this year will provide new information to better guide that process and will be referred to when relevant in the "Plan for the Coming Year" narrative of this year's application.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. As staff time is available, secure and utilize information and technical assistance from Health and Ready to Work		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Like many other states, Idaho has struggled to provide the services necessary to help special needs children make the transition to adult life. A family survey conducted as part of the five year needs assessment revealed that 49% of the parents surveyed needed much more information about services to assist with preparing their children for adulthood. National Bureau of Special Education data suggests that school systems attempt to help with this issue, with almost 75% of high school graduates reporting that their high schools helped connect them with employment and college counseling, or agencies such as vocational rehabilitation. But, outside the educational system, and especially in Idaho, very little in the way of resources exists to assist with this performance measure.

CSHP will once again attempt to work productively with Idaho's Division of Vocational Rehabilitation to better address these issues. While an informal agreement with IDVR was reached several years ago, ongoing contact with the agency ceased with personnel changes and time, so it will be necessary to renew that effort.

As mentioned in last year's narrative, in addition to planned collaborative relationships with groups across the state that are also interested in special needs transition issues, the Idaho team that attended the 2004 Champions for Progress meeting in Utah had the opportunity to meet with staff from Healthy and Ready to Work, and will plan to utilize information and assistance available from that group. Resources from HRTW's website will provide assistance in terms of data and other tools that can be used in planning strategies for this performance measure.

As CSHP staff time allows, activities to be pursued include working with youth-oriented agencies

and organizations to encourage ways to connect disabled young people to each other and adult mentors, working with state Independent and Developmental Disabilities councils to explore collaborative efforts, identifying and working with state condition-specific agencies and programs, finding ways to connect CSHP with youth leadership organizations such as 4-H, Special Olympics, and community parks and recreation programs.

c. Plan for the Coming Year

This performance measure continues to be a major challenge for CSHP, and lack of progress is due primarily to a lack of CSHP staff to address the issue in an ongoing manner and the roadblocks inherent in working productively with another bureaucracy. CSHP will continue attempts to work with Idaho's Division of Vocational Rehabilitation to better address these issues.

As mentioned previously, there are plans to utilize information and assistance available from Healthy and Ready to Work. Resources from HRTW's website will provide assistance in terms of data and other tools that can be used in planning strategies for this performance measure.

Plans also remain in place referring to activities that include working with youth-oriented agencies and organizations to encourage ways to connect disabled young people to each other and adult mentors, working with state Independent and Developmental Disabilities councils to explore collaborative efforts, identifying and working with state condition-specific agencies and programs, finding ways to connect CSHP with youth leadership organizations such as 4-H, Special Olympics, and community parks and recreation programs

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	74	76	77	80	81
Annual Indicator	70.2	69.4	79	80.8	79
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	82	83	84	85	86

Notes - 2005

NIS data for CY 2005 is not available until August, 2006.

Notes - 2004

The percentage comes for the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2003

The percentage comes for the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

a. Last Year's Accomplishments

The Immunization Program completed provider education conferences. These are regional conferences held throughout the state, focused on increasing immunization awareness, administration and storage of immunizations, as well as how to talk to parents about the importance of immunizations. The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record to verify they are up-to-date.

The Immunization Program provided free vaccines to immunize all children 0 through 18 years of age at public and private providers' sites throughut Idaho. This activity, combined with those described in the annual plan, have had a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). The most recent National Immunization Program Survey revealed that Idaho's immunization rate (4:3:1) has increased 70% to 81% for the period of July 2000 to June 2004. The Immunization Program is seeing an impressive rise in the number of children receiving the following vaccines: varicella (chickenpox), Pnuemococcal (Prevnar) and Hepatitis A. This progress can be related to the amount of education provided by the program to providers, as well as providers feeling empowered to educate parents.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide free vaccine to all children 0 - 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Perform annual site visits to all VFC providers and conduct provider education.			X	
3. Provide parent, school and daycare education, media and training.			X	
4. Maintain an immunization registry, which includes data quality monitoring.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program worked with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program worked closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program focus areas included: vaccine management and safety; provider education; reminder/recall; parent education, and review and assessment of WIC clients. Quality assurance reviews will continue with the goal to visit all VFC providers during the calendar year. In addition, the development of training plans for providers is currently underway, as well as strategic planning for the whole program. Such planning is identifying areas of importance and gaps that may exist. The most recent National Immunization Program Survey revealed that Idaho's immunization rate for the (4:3:1) is currently 84%. The program has also added two new vaccines to its universal offerings. These vaccines help protect adolescents against

Meningococcal disease and Pertussis.

The Idaho Immunization Program is also working to include appropriate and hands on training opportunities in Medical Assistant and Nurse training curricula. We currently have trained Medical Assistants throughout the Southern half of the state and are working with Nursing programs throughout Idaho to develop curricula for these programs. Immunizations are complicated and it will benefit all of Idaho's citizens if their nurses and medical assistants have a good understanding and knowledge of immunization process and practices.

c. Plan for the Coming Year

The Immunization Program will continue to provide vaccines to all children 0 through 18 free of charge to the public and private providers in the state. Development of proactive strategies to sufficiently fund this vaccine strategy are currently underway. The Idaho Immunization program will work directly with providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts. In addition, the IIP will work hard to expand its training efforts of Medical Assistants and Nurses.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider. Finally, the program will develop a plan for working more directly with parents, empowering them to take charge of their child's immunization status.

During FY 2007, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series.

Additionally, during FY 2007, the Immunization Program will continue a population-based implementation program to increase Hepatitis A and Varicella immunizations by (1) targeting children 1 to 18 years of age to have two doses of hepatitis A vaccine and 1 Varicella; and (2) providing all vaccines at no cost as part of its general statewide distribution.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program will continue to conduct or contract for activities in four major areas: (1) parent education; (2) provider education; (3) reminder/recall; and (4) review and assessment of WIC clients.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	24.9	17	16	15	14
Annual Indicator	19.0	18.4	17.5	16.8	
Numerator	604	582	545	525	
Denominator	31718	31561	31176	31340	

Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13	12	11	11	11

Notes - 2005
Data will be available September 2006.

Notes - 2004
Data from Idaho birth certificate data available due to revisions in birth certificate for 2004. Data will be available September 2005.

a. Last Year's Accomplishments
Reproductive health clinics around the state served a total of 3,272 teens in CY2005. These clients all received physical assessment, education and counseling services. Idaho's teen pregnancy rate for 15-17 year olds was 16.8, a decrease from previous years.

While all clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STD prevention, one health district conducted a survey to examine whether counseling to encourage parental involvement increases the rate of teens including parents in reproductive health care. The survey did not indicate significant increases in the percentage of teens who notify parents despite consistent counseling to do so. This has prompted the district to continue quality assurance of its counseling sessions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family planning services to teens through the public health districts.	X		X	
2. Maintain relationships with Title X compliant community health centers to become Title X compliant so they can access contraceptives through Idaho's multistate purchasing agreement. Expand the number of centers participating.	X			X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All health districts have formed partnerships with the Adolescent Pregnancy Prevention Project, an abstinence based organization funded by the Office of Adolescent Pregnancy Programs and State of Idaho Governor's Council on Prevention and Adolescent Pregnancy. The "Peers Encouraging Abstinent Kids" (PEAK) Program was initiated in Northern Idaho and has since been implemented in every health district in Idaho. The goal of the program is to teach 6th, 7th and 8th grade students how to resist peer and social pressures to become sexually active through abstinence education in the school system.

The Adolescent Pregnancy Prevention Project continued to conduct statewide print, television, and radio commercials to promote sexual abstinence.

Seminars focused on preventing sexual coercion among adolescents have been conducted throughout the state. These seminars focused on effective communication with adolescent clients faced with sexually coercive relationships. These one day seminars are designed for reproductive health providers including nurse practitioners, R.N.'s, patient educators, counselors, community health educators, social workers, and other health care providers. Registration was

open to all agencies throughout the state.

All of the local health districts have active advisory boards within their reproductive health programs which guide the content of education materials and provide direction for outreach activities. All of these advisory boards have committee members of various backgrounds, such as faith based members as well as teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups. One example is in District 3 in Southwestern Idaho, where local ministers have guided the introduction of abstinence outreach into selected youth organizations in the community.

All health districts provide extended clinic hours in the evening in order to accommodate teen clients. Confidential family planning services are provided for all teens in all Idaho Reproductive Health Program clinics.

c. Plan for the Coming Year

The PEAK increase partnerships with school districts throughout the state. Parent homework will be implemented to increase parent/child communication around sexual abstinence. There will also be more emphasis on outreach to Hispanic students with Spanish speaking parents.

With the merger of the Reproductive Health program and the STD/AIDS program into one functioning and overlapping program, the prevention effort will be increased. Staff time is being added in order to promote more time and focus on prevention messages as a whole, to including those targeted at the teen population. Comprehensive messages will be developed that target teens and encompass issues such as abstinence, STI's, parental involvement, sexual coercion, and birth control methods.

The local health department in Southwest Idaho will be conducting a series of bi-monthly sexual education classes on the Farmway Village campus. The Migrant Farm Worker Housing Development (Farmway) is a well utilized project of the county which houses 1,500 -- 2,000 Hispanic migrant farm workers and families during the course of a year. This education will target adolescents 13-19 and young adults 20-30. The classes will be presented by a bi-cultural, bi-lingual nurse.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	50	50.5	60	62	64
Annual Indicator	53.6	59.7	49.9	50.1	55.7
Numerator	10361	11430	9426	370	10315
Denominator	19332	19147	18890	739	18527
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**

Annual Performance Objective	66	68	70	72	72

Notes - 2005
Data Source 2005 Smile Survey

Notes - 2004
Data is from a survey of every third grade class in Idaho Falls school district # 91. State representative data will be available in 2005 from the Idaho State Smile Survey.

a. Last Year's Accomplishments
The MCH Oral Health Program again contracted with each of the seven district health departments to conduct population-based preventive oral health programs. A total of 491 children received free dental sealants: 341 through district clinics and 150 through Give Kids A Smile Day. Another 21,967 children received classroom education regarding preventive dental care and sealants. Five health districts conducted sealant projects targeted to schools with 50 percent or more of students on the free and reduced school lunch program. Health District 3 conducted a month long sealant clinic at Snake River Elementary, serving 191 children, and initiated discussion with the Nampa Boys and Girls Club about expanding the sealant project to include all Nampa elementary schools. In Health District 4, preventive dental clinics were held at targeted schools in Ada, Elmore and Valley counties and provided dental sealants to 55 children. Health District 5 partnered with community dental hygienists, Regence Blue Shield Caring Foundation and the College of Southern Idaho to hold two Saturday sealant clinics, serving 95 low-income children. In Health Districts 6 and 7, the oral health program coordinators worked with their dental communities and schools to plan, coordinate and facilitate Give Kids A Smile Day activities, which served 1,880 children and parents, and provided sealants to 150 children. In addition, Health District 2 prepared for a sealant project to be initiated in school year 2006, developing protocols and a manual, and purchasing a portable dental unit and supplies.

Third grade dental sealant data is from the 2005 Idaho State Smile Survey. The Smile Survey data shows that Health Districts 1, 2 and 5 have not met the HP 2010 goal of 50 percent of third grade students with one or more sealants on permanent molars. Hispanic children in this age group also fall short of the HP 2010 goal.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V support for district oral health programs will be maintained at the current level.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCH funding support for dental sealant projects is continuing during 2006 in Health Districts 2, 3, 4 and 5 and for Give Kids A Smile Day events in Health Districts 6 and 7. In addition, Regence Blue Shield Caring Foundation is providing funds to establish sealant projects at two schools in Health District 2, expand sealant clinics at four schools in Health District 4, and initiate sealant projects at four schools in Health District 5. The Caring Foundation also provides dental care to

uninsured children with treatment needs identified during screenings for the sealant clinics.

The Oral Health Program Manager will work with the MCH Research Analyst to develop and distribute an oral health report card / burden of disease report to publicize results of the 2005 Idaho State Smile Survey and highlight best practices for improving children's oral health.

c. Plan for the Coming Year
During 2007, Title V funding support for district oral health programs, including the dental sealant projects, will be maintained at the current level. Opportunities to partner with other entities to promote sealants and expand school-based programs will be explored.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	7.1	5	5	4.5	4
Annual Indicator	5.6	5.6	6.8	5.5	4.9
Numerator	17	17	21	17	15
Denominator	305087	305614	307803	308270	308270
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4	4	4	4	4

Notes - 2005
2005 data not available until September 2006.

Notes - 2004
Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

a. Last Year's Accomplishments
The Injury Prevention Program contracted with health districts statewide to provide public risk reduction for child motor vehicle related injuries. Child car safety seat education and training was delivered statewide through contracts with six of the seven Idaho public health districts. In addition, MCH funding allowed the purchase of 326 child car safety seats and booster seats that were distributed to low income parents and caregivers throughout Idaho.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Although the Injury Prevention Program will continue to monitor mortality rates for those 14 years and younger caused by motor vehicle crashes, it will shift focus to falls among elderly.				
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The Injury Prevention Program contracts with six of the seven health districts statewide to provide public risk reduction for child motor vehicle injury prevention programs. A total of $10,000 from MCH was divided among six health districts to provide child car safety seat education and training. A focus area of the contracts includes a train the trainer program in which the public health districts trained community partners to teach parents/care givers to correctly install child car safety seats.

The Injury Prevention Program and health districts statewide are working to transition the distribution of child car safety seats, and the training necessary to install those seats correctly, to state and local partners. The health districts are currently working with area partners and organizations to transition the child car safety seats program to local partners who are willing and able to house the program. All districts will have completed this transition by the end of the 2007 contract year.

c. Plan for the Coming Year
Due to a decrease in funding, the Injury Prevention Program will narrow its focus and solely address fall prevention among those 65 and older. The health districts will transfer all responsiblities of the child car safety seat program to local partners before the beginning of the 2007 contract year.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	50	50	50	50

Notes - 2005
2005 CDC National Immunizatoin Survey data is not currently available. 2004 survey data showed 50.3% of mothers breastfed at six months of age.

a. Last Year's Accomplishments
1) The Idaho WIC Program continues to promote breastfeeding initiation and support efforts for an increase in the duration of breastfeeding among infants. During FY06, Idaho continued to provide breastfeeding resource and referral information to healthcare providers, childcare centers, WIC agencies, and worksites around the state. The Idaho Department of Health and Welfare website was updated with current resources and trainings available around the state.

2) The State WIC Program worked in conjunction with Rural Connections and The Idaho Perinatal Project to provide a Breastfeeding Manual and Module to be used in rural hospitals

around the state. The goal of the Breastfeeding Module is to provide breastfeeding training to staff in rural hospitals The Breastfeeding Manual is a tool that will aid healthcare workers in providing up to date, accurate, and consistent breastfeeding information.

3) The Third Annual Idaho Breastfeeding Conference for Healthcare Professionals was held in August 2005. Breastfeeding Coalition members, healthcare providers, and Local Agency WIC staff from around the state attended. Governor Kempthorne signed a proclamation declaring August World Breastfeeding Month in Idaho. Dee Sarton, local news anchor, presented the proclamation at the conference. A planning committee that included people from around the state came together to develop an agenda that was specific to the needs of breastfeeding support in Idaho. Nationally renowned speakers were brought in and time was given during the conference to collaborate on breastfeeding promotion and support efforts from around the state.

4) Elaine Long, Phd, RD, LD (BSU Professor) presented data from the Idaho WIC computer system on breastfeeding duration, demographics, and reasons women stop breastfeeding at the WIC day of the Third Annual Idaho Breastfeeding Conference for Healthcare Professionals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement the Breastfeeding Friendly Employer Project.		X	X	X
2. Develop a Breastfeeding Training Tool Kit for WIC staff.		X		X
3. Provide breastfeeding resource and referral information statewide.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) The State WIC Program is working in conjunction with the Breastfeeding Promotion and Support Group to develop a Breastfeeding Training Tool Kit for WIC Staff. The tool kit includes lesson plans, Power Point presentations, materials for participant centered learning, anticipatory guidance prenatally and postpartum support that focuses on increasing duration.

2) The State WIC Program provided Local WIC Agencies with Best Practice Grants to achieve higher standards in breastfeeding education and support. This will also provide funding for World Breastfeeding Month activities.

3) The breastfeeding resource and referral information order form can still be found on the IDHW website, as well as information about upcoming breastfeeding trainings in and around the state and current breastfeeding information.

c. Plan for the Coming Year

1) The State WIC Program will work with Local Breastfeeding Coalitions around the state to implement the Breastfeeding Friendly Employer Project. We will submit an employee lactation policy to the Idaho Department of Health and Welfare. We will assist Local Breastfeeding

Coalitions around the state to conduct a needs assessment of major employers for policies currently in place that support breastfeeding and benefits provided to mothers who return to work and are lactating. We will provide a train the trainer workshop for select members of Breastfeeding Coalitions to implement the Breastfeeding Friendly Employer Project.

2) In FY06, the State Office will begin to support efforts of Local Breastfeeding Coalitions to hold trainings that attract healthcare professionals and community members who work with populations that would benefit from breastfeeding education to meet specific needs for their area.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	80	82.5	100	100	100
Annual Indicator	91.4	96.8	93.9	94.2	98.2
Numerator	16798	18275			21213
Denominator	18383	18886			21606
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Data not available for 2005.

Notes - 2004
Note: Responses indicating that the baby was tested after hospital discharge or that the baby was not born at a hospital but was tested were not included in the numerator and "Unsure" responses and responses with no data for that question were not included in the denominator.

Note: PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho.

PRATS data showing only the indicator.

Notes - 2003
PRATS data showing only the indicator.

a. Last Year's Accomplishments
During Calendar Year (CY) 2005, 98.2% of the babies born in Idaho hospitals were screened for hearing at birth. The Council for the Deaf and Hard of Hearing was awarded funds from the federal Maternal and Child Health Bureau through March 2008 for the Idaho Early Hearing Detection and Intervention program. The program will continue to work with its partners, including the hospitals, Infant Toddler Program, Idaho Chapter of AAP and other organizations to assure that babies who do not pass the two-stage screening are referred promptly for and receive diagnostic testing.

During CY 2005, 22 infants were identified with sensorineural hearing loss. There were also 2 infants identified with mixed hearing loss (includes permanent sensorineural loss and conductive loss) and 5 infants identified with fluctuating conductive loss.

Also, the Idaho Newborn Hearing Screening Consortium, in collaboration with and the support of the Idaho Bureau of Clinical and Preventive Services, continues to develop and refine the sustainable system for early hearing detection, intervention and follow-up of children born with a

diagnosed hearing loss.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for the Newborn Hearing Program will be maintained at the current level.			X	X
2. Match or exceed the national benchmarks set by JCIH.			X	
3. Increase family to family supsport and access to information to assist families.		X		
4. Expand newborn hearing screening to other community-based sites, e.g. district health departments.			X	X
5. Increase and improve the participation of physicians in EHDI and in the provision of a medical home.				X
6. Participate in Early Years Conference to educate early interventionists and other service providers involved in Idaho's EHDI Program.		X		
7.				
8.				
9.				
10.				

b. Current Activities

In 2005 a Memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing was renewed and the council provided:

1. monitoring and data collection;
2. hospital support, recruitment, and community education;
3. training; and
4. consortium support in an effort to increase follow-up to those families where the infant has not passed the newborn hearing screening.

c. Plan for the Coming Year

Continuing into FY 2007, the Title V agency will renew the memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing to provide services related to newborn hearing screening. The Consortium's Early Hearing Detection and Intervention will be in its 7th year of funding, and will continue to be supported by federal funding, integrated with the Infant Toddler Program (Idaho's Part C Program) dedicated to providing early intervention services to children age 0 to 3; meet or exceed benchmarks established by the Joint Committee on Infant Hearing on a statewide basis, and have 70% of hospitals achieving the benchmarks on 3 or more of the 4 performance measures.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	12.2	12.1	12	12	12
Annual Indicator	13	13	13	13	13.0
Numerator					19177
Denominator					147366

Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12	12	12	12	12

Notes - 2005
2005 CPS data not available.

Notes - 2004
2004 CPS data not available.

Notes - 2003
Data is from the Current Population Survey by the US Census Bureau for the years 2000-2001 Could not find numerator and denominator.

a. Last Year's Accomplishments
The Title V agency worked with the Division of Medicaid on outreach activities related to the implementation of the Children's Health Insurance Program (CHIP). Those efforts led to expansion of benefits for children under a new program called CHIP B. CHIP B provides coverage for children whose family incomes are greater than the CHIP A maximum allowable of 150% of the federal poverty level but equal or less than 185% of the FPL. Unlike Medicaid and CHIP A, the benefits are limited primarily to preventive health care services.

The CHIP B program was set up to have an enrollment cap as established by the state legislature. The initial open enrollment period yielded little activity. In an attempt to increase participant interest, a recruitment effort was made in conjunction with the annual back to school events at the start of the school year. This increased levels of interest and participation, but not enough to reach the program's cap.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to implement expanded CHIP coverage.				X
2. Work toward gaining expanded Medicaid coverage for young women of reproductive age.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The lack of interest in the CHIP B program raises the question of how many families are truly in need of health insurance that are not currently covered by Medicaid or CHIP A. The program has a continual open enrollment.

c. Plan for the Coming Year
The Title V program will continue to work with the Division of Medicaid to promote the CHIP B program to eligible children. The Title V Program will continue to work with Medicaid to expand eligibility for medical services for women and children. The program will continue to utilize the

Idaho CareLine to identify needs, locate services for families and make referrals for services. The Title V program will utilize grant funds to provide services through contracts with public health districts for needed services for women and children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					28.9
Numerator					5240
Denominator					18137
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	26	24	22	20	18

a. Last Year's Accomplishments
This performance measure is new, therefore, no accomplishments were made last year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate Idaho Fit Kids Project.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Through the Idaho Fit Kids Project, the Health Districts trained 141 physician offices in the state.

125 families requested additional information through a series of newsletters.

Evaluation is currently underway and will be completed by the end of Calendar Year 2006.

1. Chart reviews are being conducted in the physician offices which received the training to measure whether or not BMI was assessed.

2. Physician offices are being asked a few questions regarding the project using an interview format. This interview is occurring at the same time as the chart review.

3. Written surveys are being distributed to the families who requested more information for the purpose of determininng if they found the information helpful.

c. Plan for the Coming Year
Follow-up projects will be considered based on the project evaluation results.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	8	8	8	7	7

Notes - 2005
2005 data available in September 2006.

a. Last Year's Accomplishments
PRATS data indicate that 9.3 percent of women smoked at some time during their pregnancy. Data also indicate that mothers who smoked during the last three months of their pregnancy were 22.5 times more likely have their baby preterm (8.7 percent preterm) than mothers who did not (7.1 percent preterm). A high majority of women who smoked prior to becoming pregnant (93.4%) indicated that they were given information about the effects of smoking during their prenatal visits.

The Idaho Reproductive Health Program served 33,703 clients including 2,885 pregnant women. Each client given a pregnancy test was provided with education regarding tobacco use while pregnant. Women who were found to be pregnant were screened for high risk behaviors and referrals were made as indicated.

The Idaho WIC program screens all pregnant women for tobacco use. There is currently no good data as to the number of women that WIC sees who do smoke. If a client does self-report that they use tobacco, WIC makes the appropriate referral to either a substance abuse program or a smoking cessation program.

Each of the seven health districts throughout Idaho provides smoking cessation classes to their clients. Districts 1 and 2, both in northern Idaho, target pregnant women specifically. The Idaho Tobacco Program also provided materials about the risk associated with smoking while pregnant to the local health districts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Alcohol, tobacco, and other drugs initiative.			X	X
2. Provide family planning services to educate pregnant women on the risk of tobacco use.	X		X	
3. Provide WIC services to pregnant women.			X	

4. Continue tobacco cessation classes at local health districts.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Idaho Reproductive Health Program and the WIC program continue to screen women for tobacco use before and during pregnancy. Referrals are made as indicated.

The Keep Infants Safe from Smoke (KISS) project is a collaborative effort between the Idaho Tobacco Program and the Idaho Asthma Program. The KISS project targets women who smoke or who live with a smoker. New mothers will be screened for tobacco use in the hospital maternity ward. If a new mother smokes or lives with someone who smokes, a health care provider will provide her with smoking cessation education and education on the harmful effects of tobacco smoke. A follow-up visit 3-6 months after the initial visit will screen for tobacco use again. During this visit, a care package will be provided to the new mother. Pregnant women will also be screened by their doctor's office or clinic during prenatal visits. They will receive initial smoking cessation education at the doctor's office or clinic, and the hospital that delivers the baby will conduct the follow-up screening. Focus groups will be conducted with low income pregnant women to evaluate the packet materials.

c. Plan for the Coming Year
The KISS project will be piloted in Districts 1 and 2 where rates of smoking while pregnant are the highest. Following a positive evaluation of the pilot project, this plan will be implemented statewide.

The SSDI program will work to establish new data linkages and improve access to survey data. New data linkages include a link between WIC client files, birth records, and corresponding Pregnancy Risk Assessment Tracking System (PRATS) survey responses and an on-going (yearly) linkage between birth, infant death, and stillbirth records. The program will also develop and implement quality control measures for the PRATS data collection, handling, and analysis process and work to improve access to and utilization the data.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	16.7	20	19	13	12
Annual Indicator	21.3	13.7	13.8	13.8	
Numerator	24	15	15	15	
Denominator	112936	109671	108796	108840	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	11	10	9	9	9

Notes - 2005
2005 data not available until September 2006.

Notes - 2004
Idaho mortality database not finalized because not all out of state deaths certificates have been received. Data will be available September 2005.

a. Last Year's Accomplishments
Better Todays. Better Tomorrows. (under a grant from the Governor's Generation of the Child Initiative) has been conducting children/youth mental health education programs for caregivers and gatekeepers. These focus on warning signs of mental disorders and subsequent risks for suicide. Better Todays is a program of Idaho State University Institute of Rural Health in partnership with NAMI-Idaho, the National Child Traumatic Stress Network and the National Institute for Mental Health. It has been named a promising practice by the National Child Traumatic Stress Network, SAMHSA and the Rural Mental Health Association and has been featured in Advances in School-Based Mental Health Interventions and an article (in press) in the journal Professional Psychology Research and Practice.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Youth Suicide Prevention Early Intervention Coalition, a State-level public/private partnership.				X
2. Provide gatekeeper training for university residence hall staff, other student staff, and other community gatekeepers.				X
3. Continuation of TeenScreen.				X
4. Statewide suicide prevention referral sources will be available through 2-1-1 Idaho CareLine.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Better Todays. Better Tomorrows. continues to children/youth mental health education programs for caregivers and gatekeepers. Better Todays is also partnering with the Department of Health and Welfare Family and Community Services bureau to conduct trainings surrounding children's mental health and suicide risks to law enforcement agencies statewide.

c. Plan for the Coming Year
The ISU Institute of Rural Health will be expanding their work under the suicide prevention plan. The anticipated activities include providing technical assistance to communities in implementing the TeenScreen depression/suicide risk screenings; supporting SPAN Idaho's education efforts; supporting the SPAN chapters' local activities and building lasting statewide infrastructure for suicide prevention; preparing education/marketing tools for dissemination by the regional SPANs; and conducting trainings and other outreach activities concerning suicide risk and programs for Native Americans, Hispanics and Asian/Pacific Islanders. An advisory committee of suicide prevention advocates will be convened to advise ISU during the course of their activities.

POST Academy is applying for funding to expand their education program and identify sustaining

methodologies under a grant from the Department of Justice.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	58.6	65	66	75	75
Annual Indicator	59.5	65.7	72.8	99	
Numerator	119	132	142		
Denominator	200	201	195		
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	75	75	75	75

Notes - 2005
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure.

Notes - 2004
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 was entered to allow form to be saved.

Notes - 2003
Data for very low birth weight babies born at high-risk facilities are based on Idaho resident births in Idaho. Idaho does not receive hospital name for out of state births, therefore designation of high-risk facilities for babies born out of state is not available. Numerator is based on births to Idaho residents in Idaho and denominator is based on Idaho resident births.

a. Last Year's Accomplishments
In CY 2005, the Idaho Reproductive Health program provided education and counseling to 33,703 clients seeking reproductive health services in its clinics. Within this population, 2,885 pregnant women received education on proper nutrition, folic acid supplements, and other preconception information including the use of tobacco, alcohol and other drugs to prevent pre-term, low birth weight deliveries.

The Bureau of Clinical and Preventive Services contracted with the Idaho Perinatal Project to begin work with lay midwives throughout the state. The intent was to develop a stronger relationship between lay midwives and advisory organizations like the Perinatal Project to improve education, training and resources for lay midwives who may have patients at high risk for a variety of reasons, but including the risk of delivering a low birth weight baby.

Work began on the development of the Idaho Oral Health Project for Pregnant Women. A review of the literature was conducted to pull together the current science behind the suspected link between periodontal disease and preterm, low birth weight deliveries. This literature review provided the foundation to begin exploring the development of a project in Idaho that would bring together dentists and prenatal care providers in a collaborative effort to impact birth outcomes in a positive way.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. Reproductive Health Program will provide pregnancy tests and make referrals as appropriate.	X		X	
3. Continue Lay-midwife project with Idaho Perinatal Project.			X	X
4. Continue implementation of Oral Health for Pregnant Women Project.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Idaho Perinatal Conference held in February sponsored 2 midwives to attend the conference to increase their knowledge and skills and form a relationship as the leading place for continuing education. The Idaho Perinatal Project (IPP) partnered with the Idaho Midwifery Council to expand its lending library to allow greater access for midwives around the state. IPP is also working to develop certified professional midwife credentials as the basis for midwifery licensure in Idaho.

The Idaho Perinatal Project purchased two childbirth simulators and labor/delivery module sets for use in training around the state. These simulators are used to train new OB nurses or those in small rural hospitals on the hands on skill needed during a high risk delivery. In small rural hospitals that may see one high risk pregnancy a year, these have been an invaluable tool to keep their skills up and decision making abilities fresh. Currently these simulators are located in small hospitals in Panhandle and Central Idaho locations. Other training modules in conjunction with the simulators have also been conducted and proven effective in developing skills sets to deliver high risk deliveries.

The Idaho Oral Health Project for Pregnant Women was officially established. A work plan was developed including goals and objectives for this 3-5 year project. A state leadership team was established which consisted of representatives from the Bureau of Clinical and Preventive Services, the Idaho Oral Health program, Medicaid, dentistry, dental hygiene, the Idaho Academy of Pediatrics and the Idaho Chapter of the American Council of Obstetrics and Gynecology. The kick off meeting for the project was held in February and included a presentation from Michael Shirtcliff, DMD and founder of Advantage Dental in Oregon. All seven health districts participated in strategic planning to begin bringing dentists and physicians together at a local level.

c. Plan for the Coming Year

Work will continue with Idaho Perinatal Project to strengthen the relationship between IPP and the Idaho Midwifery Council. Proposed credentialing will move forward as the group identifies what regulations they want to put into place. The IPP plans to enhance and maintain its

communication effort with all stakeholders involved. This will be key in gaining input and support on proposed regulations and making changes within the state.

An evaluation of the need to purchase additional childbirth simulators will be done to determine where throughout the state hospitals would benefit from the hands on training. One focus of the Idaho Perinatal Winter Conference this year will be best transport options for high risk deliveries. This will focus on getting a high risk pregnant mom transported to the most skilled hospital prior to delivery so she can be in the right place for her delivery.

The Idaho Oral Health program will begin monitoring the work plans and accomplishments of those health districts participating in the project in order to determine any changes that need to be made for the project to continue moving forward. Work will be done to strengthen the referral network within the state so that when a physician finds a woman at high risk for periodontal disease, there is a place to send her for treatment. This is a major concern of the State Leadership Team. The Idaho CareLine will be involved in this effort by conducting a survey of dental care providers to identify those that will accept at risk low income women.

Data collection will be strengthened through the use of PRATS and Medicaid data to evaluate the number of women being told about the need for dental care during pregnancy and the number of women seeking treatment while pregnant. Through this data we will also be able to monitor the number of low birth weight deliveries to women with diagnosed periodontal disease.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	80.7	80.8	83	84	85
Annual Indicator	81.9	82.1	81.3	71.9	
Numerator	15807	16710	17091	15455	
Denominator	19309	20362	21012	21502	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	86	87	88	88	88

Notes - 2005
2005 data not available until September 2006.

Notes - 2004
in 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2003
Data based on records with known data for prenatal care and are for Idaho resident births.

a. Last Year's Accomplishments
During CY 2005, 33,703 women received counseling from the Idaho Reproductive Health program. Of those women, 2,885 were found to be were pregnant. Those women who were found to be pregnant were screened for high risk behaviors and referrals were made as indicated.

All women were referred for prenatal care and Medicaid, if needed, to promote early prenatal care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Reproductive Health Program will provide pregnancy testing and referral for prenatal care.			X	
2. Utilize Pregnancy Risk Assessment Tracking System (PRATS).				X
3. The WIC Program will provide nutitional counseling and information on other pregnancy risk factors.			X	
4. The Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently through the lay-midwife contract that the Bureau of Clinical and Preventive services has with the Idaho Perinatal Project, a media campaign has been developed to encourage women to choose their prenatal care provider and seek care as early as possible. The mode of delivery is primarily through radio; however, educational materials surrounding healthy pregnancy have been developed and distributed throughout the state.

c. Plan for the Coming Year

Planning for a comprehensive prenatal project focusing on educating women about how to have a healthy pregnancy will begin. This project will encompass issues such as perinatal and post-partum depression, early prenatal care, dental care during pregnancy, proper nutrition, and substance abuse including smoking while pregnant. It will target low income and minority populations as well as small, rural communities that have little in the way of resources.

D. State Performance Measures

State Performance Measure 1: *Percent of mothers who were screened for post partum depression within one month following delivery.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				0	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**

Annual Performance Objective	75	75	80	80	80

Notes - 2005
No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data.

Notes - 2004
No data is available at this time.

a. Last Year's Accomplishments
No data available.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Complete needs assessment to identify use of screening tools.				X
2. Develop project centered on post-partum depression to identify and address barriers facing women with post-partum depression.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Idaho Perinatal Project distributed post-partum depression screening tools to all hospitals that attended the annual Nurse Summit meeting held in October. It is unclear how these tools are being used and what resources the hospitals are utilizing when they identify a woman at risk.

c. Plan for the Coming Year
A needs assessment will be conducted at the Nurse Summit meeting to identify the use of the screening tools, what is working, what is not working, and what direction the hospitals would like to see their programs head. Data collected from this evaluation will assist the Bureau of Clinical and Preventive Services and the Idaho Perinatal Project in developing a project centered on post-partum depression. It is anticipated that the project will assist small rural hospitals in identifying and addressing some of the barriers faced by women experiencing or at risk of post-partum depression.

State Performance Measure 2: *The percent of Medicaid and SCHIP children ages 1 and 2 that received the expected number of EPSDT screens.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					

Annual Indicator					70.5
Numerator					16834
Denominator					23865
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	80	81	82	83

a. Last Year's Accomplishments

The Medicaid program continued to send our reminder letters to all eligible children who had an upcoming well-child check. These letters have been very effective in the past in increasing the number of EPSDT screens that are occurring.

Data collected from the 2003 Healthy Connections Client survey indicated that 71% of children received a well child check within the previous year. The data also indicated that 73% of clients received a reminder letter about their upcoming well child check. Medicaid data however, did not support this finding and therefore a series of studies were conducted to identify if in fact children were getting in and if not why. The studies indicated that the error in data may have been coming from the Medicaid Management Information System and that it was possible that physicians were not coding EPSTD screenings appropriately.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue referral as necessary for children who do not have a regular health care provider.		X		
2. Reminder letters sent to all children enrolled in Medicaid.		X		
3. Enhance preventive services targeted to young children and families through Medicaid.	X			X
4. Continue monitoring Medicaid data to evaluate number of children receiving appropriate screens.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A study was launched by the Division of Health in collaboration with Medicaid to try to understand if Medicaid children were seeing a physician regularly for well child check ups and if appropriate screenings were occurring during these visits. Focus groups were held in twelve sites throughout Idaho with families enrolled in Medicaid and the Women, Infants and Children (WIC) program. Questions were devised to elicit the following information: Did these families have a regular doctor? When the child went to the doctor did they receive the appropriate services (e.g. immunizations, blood lead screening)? Were there barriers to visiting the doctor specifically for well-child checks? Did they receive the reminders from Medicaid and were they helpful? Data revealed that it varied throughout the state to some degree, but that most families had a regular doctor. They reported that they often missed well-child checkups because they did not feel a trip to the doctor was needed unless their child was ill. They also reported that in some cases immunizations were not given in the physician's office or during a well child check. And that most parents did not know anything about blood lead screening unless they lived in specific geographic locations in Idaho. Many parents reported having received the reminder letter from Medicaid, but the vast majority agreed that a postcard or phone call would be a better avenue.

c. Plan for the Coming Year
Work will continue to increase the number of children receiving appropriate EPSDT screens. Through Medicaid reform that the state is currently under-going, children and families are a population that will see changes. The new program will focus on approaches that will encourage individuals to make good health decisions.
By enhancing preventive services, this program will provide incentives for accessing appropriate exams and screening services rather than waiting until needs become acute. Individuals will have the opportunity to establish personal health accounts that will enable them to purchase goods and services that will support active and healthy lifestyles.

State Performance Measure 3: *Percent of 9th - 12th grade students that report having engaged in sexual intercourse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					

Notes - 2005
2005 YRBS Survey Data available in June 2006.

Notes - 2004
YRBS survey not completed in 2004.

Notes - 2003
Data Source YRBS survey. Numerator/Denominator not available.

a. Last Year's Accomplishments
Reproductive health clinics around the state served a total of 3,272 teens in CY2005. These clients all received physical assessment, education and counseling services. Idaho's teen pregnancy rate decreased to 16.8 compared to the CY2004 rate of 17.5 for 15-17 year olds.

While all clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STD prevention, one health district conducted a survey to examine whether counseling to encourage parental involvement increases the rate of teens including parents in reproductive health care. The survey did not indicate significant increases in the percentage of teens who notify parents despite consistent counseling to do so. This has prompted the district to continue quality assurance of its counseling sessions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support local health district advisory boards, which guide education materials and outreach.		X	X	
2. Ada County Juvenile Detection Center project.			X	
3. Reproductive health information through high school classes.		X		
4. Partner with local youth peer mentoring program, "Youth in the Know."				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All of the local health districts have active advisory boards within their reproductive health programs which guide the content of education materials and provide direction for outreach activities. All of these advisory boards have committee members of various backgrounds, such as faith based members, as well as teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups. One example is in District 3 in Southwestern Idaho, where local ministers have guided the introduction of abstinence outreach into selected youth organizations in the community.

At the local level, an important outreach to the general public includes the health department websites. The Central District Health Department Reproductive Health web pages have been reviewed with the male outreach advocate and revised as appropriate. A major outreach to adolescents is the senior high school newspapers. Prior to renewal this year, input was sought on these ads from youth attending the Teen Clinic and revised the ads in response. An ad was also placed in the fall high school football publication "Pigskin Preview" which was widely distributed throughout the community and expected to have a primarily male audience. Presentations were also offered to every high school in the Boise, Meridian and Kuna school districts. A total of 700 students attended these presentations.

All health districts provide extended clinic hours in the evening in order to accommodate teen clients. Confidential family planning services are provided for all teens in all Idaho Reproductive Health Program clinics.

c. Plan for the Coming Year

The Ada County Juvenile Detention Center project will continue, which provides access to reproductive health care services for high-risk male adolescents. Residents will be given the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations will be given to measure the level of intention to the change of risky sexual behaviors.

Area high schools will also receive more reproductive health information in their health classes. Emphasis will be on the ABC approach and increasing the understanding of gender roles responsibilities in preventing STI's and pregnancy.

Finally, partnering with the local youth peer mentoring program "Youth in the Know" will increase the understanding of teenage sexuality and reproductive health issues.

State Performance Measure 4: *Percent of 9th – 12th grade students who used any type of tobacco in the past 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			17.8	14	14
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2005
2005 YRBS data available in June 2006.

Notes - 2004
The Idaho Child Mortality Review Team has been disbanded. A summary of their 5 years of work will be developed as a final document produced by the team. Essentially, the first few years of reviews idenfitied areas for improvement and, as such, recommendations were made. In the most recent year or two, the team believed they were basically reviewing similar types of deaths and that recommendations were just being repeated.

The manner in which the data was being reported in 1999 compared to 2000 and 2001 is the reason the rate of review had declined. All the deaths are reviewed by a subcommittee of the team, but only those that are believed to have been preventable, are reviewed in detail by the entire team. These preventable deaths, such as homicide, suicide, and SIDS, were the only ones reported as reviewed in 2000 and 2001. The objective is still correct in the sense that 100% of all those eligible for review were in fact reviewed.

This measure will be replaced next year following completion of the 5 year needs assessment.

Notes - 2003
The Idaho Child Mortality Review Team has been disbanded. A summary of their 5 years of work will be developed as a final document produced by the team. Essentially, the first few years of reviews idenfitied areas for improvement and, as such, recommendations were made. In the most recent year or two, the team believed they were basically reviewing similar types of deaths and that recommendations were just being repeated.

The manner in which the data was being reported in 1999 compared to 2000 and 2001 is the reason the rate of review had declined. All the deaths are reviewed by a subcommittee of the team, but only those that are believed to have been preventable, are reviewed in detail by the entire team. These preventable deaths, such as homicide, suicide, and SIDS, were the only ones reported as reviewed in 2000 and 2001. The objective is still correct in the sense that 100% of all those eligible for review were in fact reviewed.

This measure will be replaced next year following completion of the 5 year needs assessment.

a. Last Year's Accomplishments
While 9th and 12th graders are not a direct focus of Project Filter due to the low smoking rates of Idaho's youth, Project Filter did provide the American Lung Association of Idaho with a grant to implement their Teens Against Tobacco Use (TATU) and Not on Tobacco (NOT) programs in Idaho schools. The TATU and NOT programs train high school students in tobacco prevention

skills that they use as peer educators in their schools. The TATU program trained 434 peer educators and NOT 112 youth. TATU youth presented to 8731 peers and reached over 20,000 individuals through marketing efforts and school announcements. All activities were coordinated through the American Lung Association and local Health District offices.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate and implement TATU program in 5 of 7 health districts.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Due to budget cuts, the American Lung Association was not funded to conduct either TATU or NOT. During this fiscal year, only 2 of the 7 Health Districts chose to continue the TATU program. No other direct activities are planned for this year.

c. Plan for the Coming Year
Project Filter will once again be working with the American Lung Association and 5 of 7 Health Districts in the coordination and implementation of the TATU program in local schools. The focus this year will be placed on rural schools and those who don't usually receive extra programs.

State Performance Measure 5: *Percent of pregnant women who received dental care during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				39.4	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	50	50	50	50

Notes - 2005
2005 data not available.

Notes - 2004
Responses with unknown data were not included in the denominator.

Note: PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho.

a. Last Year's Accomplishments

During 2005, groundwork was laid for an Idaho Perinatal Oral Health Project to integrate oral health with prenatal care. Planning meetings were held with key stakeholders, a literature reviewed conducted, information on other States' programs obtained, and a project work plan drafted. Medicaid data on dental access for pregnant women and costs associated with low birth weight (LBW) deliveries were analyzed and will serve as a baseline for project evaluation. Idaho birth certificates and the Idaho Pregnancy Risk Assessment Tracking System (PRATS) will also be used for data collection, project monitoring and evaluation.

The project goal is to develop the needed infrastructure throughout Idaho for pregnant women to be educated about the importance of dental care during pregnancy and to refer those with oral health risk factors or untreated dental disease for care as needed. The target population is pregnant women, particularly those served through the Medicaid Program. During SFY 2004, 42 percent of Idaho deliveries were paid by the Medicaid Program and 6.9 percent were LBW. The cost five days from date of birth for a LBW Medicaid delivery was $35,776, compared to $3,500 for a non-LBW delivery. One year from date of birth, the cost for 490 Medicaid LBW deliveries was $17.5 million. Only 13 percent of pregnant women covered by Medicaid received any dental service during SFY 2004.

The Idaho Perinatal Oral Health Project objectives are:
1. To educate health providers and consumers about the possible link between maternal periodontal health and birth outcomes and the importance of good oral health and dental care during pregnancy.
2. To integrate oral health with prenatal care by having medical providers conduct oral health screening, provide education, and make referrals to dental providers.
3. To improve pregnancy outcomes by identifying women with periodontal problems and referring them for needed dental care.

In September 2005, the MCH Special Projects Manager and the Oral Health Program Manager were part of the Idaho team that attended the CHCS Purchasing Institute Best Practices for Dental Access. National leaders presented information on improving oral health for mothers and children and provided technical assistance in drafting a strategic plan to improve oral health and access to preventive dental care for Medicaid recipients.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish referral network for physicians and dentists.				X
2. Conduct survey of dentists regarding acceptance of Medicaid referred patients.			X	X
3. Continue evaluation of PRATS and Idaho Birth Certificate data.				X
4. Continue to improve dental coverage for pregnant women through Medicaid.				X
5. Educate providers and pregnant women regarding link between good oral health and improved birth outcomes.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A state leadership team was formed and meetings held to refine the perinatal oral health project work plan. Leadership team members include representatives from the dental community, the Idaho Perinatal Project, ACOG, WIC, Medicaid, the State and Health Districts. The state leadership team is led by the MCH Special Projects Manager and the Oral Health Program Manager.

A project kick-off was held February 2, 2006, in conjunction with the Idaho Perinatal Project Winter Conference. Dr. Kathy Phipps, epidemiologist consultant, presented the science on periodontal disease and birth outcomes to conference participants, state leadership team members, and leadership teams from each of the health districts. In the afternoon, state and district leadership teams heard a presentation on Idaho Medicaid costs related to deliveries and dental access for pregnant women. Dr. Michael Shirtcliff presented information on a Klamath County, Oregon, Robert Wood Johnson project with pregnant women and how it has reduced early childhood caries and preterm births. Leadership teams then participated in strategic planning to develop local implementation plans.

MCH Title V funds for local project implementation to engage dental and medical providers have been provided through contracts with each of the health districts. In addition, six of the seven health districts received funding support to send their oral health program coordinators to the 2006 National Oral Health Conference, where information on national and state perinatal oral health projects was presented.

We are currently working with a marketing agency to develop design concepts and project materials for a coordinated and focused statewide community outreach. Plans are to develop and disburse educational and professional resource materials to dental and medical offices.

A public service announcement on the importance of good oral health during pregnancy was aired from August through December 2005 on all television stations in the southwest Idaho market. PSA placements targeted low income women age 18-34 years. The estimated viewing audience was 51,120. Funding for developing and airing the PSA came from the Title V MCH and SOHCS grants, Delta Dental of Idaho, Regence Blue Shield, Willamette Dental, Blue Cross of Idaho, and an individual donor.

A survey of dentists in partnership with the Idaho CareLine is planned for Summer 2006 to establish a database for physician to dentist referrals.

Site visits will be conducted with local leadership teams to evaluate progress; discuss barriers, challenges and successes; and outline year two activities.

c. Plan for the Coming Year

During 2007, perinatal oral health project efforts will build on year one accomplishments. Contracts will be generated with each health district upon receipt and approval of their second year project implementation proposal. Medicaid, PRATS and Idaho birth certificate data will be analyzed and reviewed with state and local leadership teams. Additional resources will be developed based on district and leadership team recommendations. A statewide media outreach during 2007 via television and/or radio is being considered.

State Performance Measure 6: *Percent of Medicaid and SCHIP children who are fully immunized by age 2.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					

Annual Indicator					80
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	90	90

Notes - 2005
Data is an estimate from IRIS data.

Notes - 2004
Data is from a survey of all kindergarten classes in Idaho Falls school district # 91. State representative data for children age 5 years will be available in 2005 from Idaho State Smile Survey of kindergarten students and in 2006 from Head Start Smile Survey.

a. Last Year's Accomplishments
The Idaho Immunization Program has been conducting immunization coverage assessments of Medicaid children age 24-35 months of age annually since 2000. This effort was part of a national collaboration between the CDC and CMS to identify at risk Medicaid children and target immunization efforts where possible. Data consistently showed that Idaho Medicaid children were significantly under-immunized (up to 15% difference in rates) when compared to non-Medicaid or privately insured children. Children enrolled in the WIC program were also assessed to determine what role, if any, WIC played in immunization rates of its clients. It was determined that the WIC program had a positive impact on rates and that in fact may have been inflating the Medicaid immunization rate as these populations have no clear dividing line. This prompted research to identify where the problem lay and what could be done to address the issue. A position paper was drafted which provided recommendations.

Beginning late 2005, the Idaho Immunization Program began conducting chart reviews in physician offices and specifically identifying which children were Medicaid, which were non-Medicaid, and what the immunization rate was for each population. This was a targeted project on 25 of the largest providers in the state. The project lasted for 5 months.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing evaluation of the Medicaid population's immunization rate through chart review.				X
2. Ongoing evaluation of the state immunization rate for all children.				X
3. Referral for immunization through WIC linkage.				X
4. Educate public regarding immunization awareness.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In early 2006, twelve focus groups of Medicaid clients were recruited, conducted and moderated by an outside contractor. Eight focus groups were conducted in English with 69 participants and

four groups were conducted in Spanish with 17 participants. Four of the focus groups (3- English and 1-Spanish) were conducted with participants who were either inactive in WIC or never enrolled. There were four main focuses of the group discussion -- well-child check ups, immunizations, WIC and blood lead screening. The intent was to understand what incentives and barriers impacted the parent's decision to immunize their child, was the current reminder system effective, and what role did WIC play.

A provider survey was conducted to gain provider insight to the Medicaid population. It was hoped that through these surveys we would see patterns that might impact accessibility and the care that Medicaid children are receiving.

The study concluded mid-year and the findings showed that Medicaid children are equally as immunized as non-Medicaid children, 78% and 77% respectively. The results were compared to other data collected on a larger sample through contracts with public health agencies and site reviews conducted in private provider offices, and found that the data were comparable.

c. Plan for the Coming Year
Even though the data suggest that Idaho Medicaid children are as immunized as non-Medicaid children, the Bureau of Clinical and Preventive Services and the Idaho Immunization Program (IIP) will continue to monitor the data. The IIP has established protocols which now include the collection of insurance type on all children reviewed during site visits conducted by the IIP. This data will be entered into CASA and analyzed. Should we start to see a difference in the rates between Medicaid children and non-Medicaid children, steps will be taken to address the difference.

State Performance Measure 7: *Percent of 9th – 12th grade students that are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			7.4		7.2
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2005
2005 YRBS survey data available in June 2006.

Notes - 2004
YRBS survey not performed in 2004.

Notes - 2003
Data Source YRBS, numerator/denominator not available.

a. Last Year's Accomplishments
In the spring of 2005, a statewide physical activity and nutrition needs assessment was conducted, utilizing seven public forums around the state to gather input on needs, available resources, and service gaps.

In June 2005, action planning was initiated with the Governor's Physical Activity and Nutrition Summit held in Boise. Subsequent planning sessions in October and November 2005 were convened to identify priority short-term goals and strategies. An expert statewide task force of 15 decision-makers and practitioners, invited by the Governor, participated in the planning sessions.

In December 2005, a "quick start" action plan was presented to Governor Kempthorne. The goals and strategies represent a starting point to decrease the prevalence of sedentary lifestyle and poor eating habits in Idaho.

Elements of the action plan were begun by IDHW's Physical Activity and Nutrition Program. Key messages for physical activity and nutrition were identified, and a marketing firm hired to craft them into marketable form. School wellness policy development was supported by offering technical assistance to schools and school districts seeking help. The Governor initiated a new state employee wellness program.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop media campaign to encourage families to become more active and eat better using Idaho CareLine.		X		
2. Technical assistance will be made available to schools regarding their school wellness policies.				X
3. Formalize a state Physical Activity and Nutrition Alliance/Coalition.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We are currently crafting the "marketable" universal messages with a marketing firm. We are developing a media campaign to encourage middle-income to low-income families to become more active and eat better, with the opportunity to use the Idaho CareLine 211 to obtain ideas that can be used at home.

c. Plan for the Coming Year

We will continue to develop a media campaign, including two television commercials, to give parents ideas on how to get the children and entire family more active and eating better. Resources will be developed and made available via Idaho CareLine 211.

Healthier food choices will be made available in state building vending machines, working with the State Commission for the Blind and Visually Impaired.

Technical assistance will continue to be available to schools desiring help crafting or improving their school wellness policies.

A state Physical Activity and Nutrition alliance/coalition will be formalized to continue working

toward action plan goals.

E. Health Status Indicators

The heath status indicators provide quite comprehensive demographic information, as well as select birth, death and condition information. While all of this information is available elsewhere, it consolidates key measures of significance to the MCH population and program in one area.

This data allows us a comprehensive picture of whom current funding is affecting either directly or indirectly. Through the evaluation of outcomes from each of these programs or areas, we are able to weigh the impact of our funding and shift funds as necessary in order to serve the most individuals at highest risk. While this state level data may assist in program direction, Idaho efforts such as the expanded PRATS survey make it possible for us to look at the issues at a more local level.

Surveillance of these key indicators allows us to monitor our progress in relationship to other MCH programs. The indicators are not particularly useful for evaluation purposes.

F. Other Program Activities

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Idaho has made the decision to consolidate PKU services under one physician in an effort to provide consistent care from birth through 18. Dr. Ron Scott will discontinue staffing Idaho clinics during the summer of 2005 and Dr. Cary Harding from Oregon Health and Science University will be taking his place. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.

The MCH research analyst, Greg Seganos, and the MCH Special Projects Coordinator, Traci Berreth, have recently completed the publication of the Bureau of Clinical and Preventive Services outcome performance measures. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis, as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

The Idaho Fit Kids Project is a year long pilot project focusing on the use of BMI as a predictor of risk for overweight in children and providing families with helpful tips on health. The Division of Health contracted with the District Health Departments in the state to provide training to pediatrician and family practice offices in their service area. The trainings include factual information on BMI, ideas for incorporating BMI into practice and how to provide parents with guidance related to their child's healthy growth.
Each Health District has been contracted to provide up to 25 trainings between March 1, 2005 and October 31, 2005. The Division of Health provided training to the Health Districts regarding this project in January 2005.

Through the trainings provided by the Health Districts, physician offices will receive "Idaho Fit Kids" handouts for patients, CDC growth grids, and a card for families to mail to the Department

of Health and Welfare if they would like to receive more information related to healthy growth. The families who return the request for information card will receive a series of 6 newsletters in the mail from the Division of Health. The newsletters will contain tips on eating healthy and activity.

To date, the Health Districts have trained over 30 physician offices in the state.

Evaluation will take place in January 2006 and will include:

1. Chart review of physician offices which received training to measure whether or not BMI was assessed.

2. A written survey will be mailed to families who requested more information for the purpose of determining if they found the information helpful.

3. Physician offices will be asked to complete a brief survey during January 2006 related to the project.

/2007/ Through the Idaho Fit Kids Project the Health Districts trained 141 physician offices in the state. 125 families requested additional information through a series of newsletters. Evaluation is currently underway and will be completed by the end of calendar year 2006.

1. Chart reviews are being conducted in the physician offices which received the training to measure whether or not BMI was assessed.
2. Physician offices are being asked a few questions regarding the project using an interview format. This interview is occurring at the same time as the chart review
3. Written surveys are being distributed to the families who requested more information for the purpose of determining if they found the information helpful.

Follow-up projects will be considered based on the project evaluation results. //2007//

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 34,190 children grades 1-6 in 2004. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 51,747.

/2007/ The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 33,754 children grades 1-6 in 2005. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 56,795. //2007//

The MCH Oral Health Program continues to fund early childhood caries (ECC) prevention and fluoride varnish projects for WIC clients, Head Start children, and children who are Medicaid/CHIP eligible. During 2005, 13,323 children received preventive dental services, including 3,020 who received fluoride varnish applications, and 7,382 parents, teachers, dental and medical health professionals served through education and community outreach efforts.

The State Oral Health Collaborative Systems (SOHCS) Grant to integrate oral health with well child care was implemented during 2005 in southwest Idaho. Trainings in early childhood caries prevention and fluoride varnish application were provided to 36 dental and 93 medical professionals, including the Family Practice Residency of Idaho faculty, residents and nursing staff; St. Luke's Cystic Fibrosis Clinic nurses; the Ada Canyon Medical Education Consortium; health district immunization clinic nurses; and private practice dentists, physicians and staff. The project also included media outreach to an estimated 51,120 women age 18-34 years through public service announcements developed in partnership with Idaho Oral Health Alliance members.

The Oral Health Program helped convene the Idaho Head Start Oral Health Forum in November 2004. Forum follow-up included development of an Idaho Head Start Oral Health Action Plan and motivational interview trainings with a focus on oral health, presented by Dr. Philip Weinstein, University of Washington, during September 2005. The motivational interview trainings were held in six population areas of the state and were attended by 244 Head Start, WIC and district dental staff. A smile survey of Idaho Head Start children is currently underway.

The 2005 Idaho State Smile Survey collected oral health data on 6,300 kindergarten, third and sixth grade students.

G. Technical Assistance

The Idaho Oral Health Program may request technical assistance to support the prenatal oral health project that is currently in the planning stages for implementation in FY 2006.

The goal of the project is to integrate oral health with prenatal care. The target population is pregnant women, particularly those served through the Medicaid Program. The Idaho Medicaid Program pays for approximately 40% of all deliveries. Efforts will be made to engage both medical and dental care providers in the effort. Project partners will include the Medicaid Healthy Connections Program, the District WIC and Oral Health Programs, as well as representatives of professional and community organizations with an interest in maternal and child health.

Project objectives are to increase awareness of the link between oral health and birth outcomes and increase access to periodontal care that can improve pregnancy outcomes. Medicaid data on dental access and costs associated with deliveries and preterm births will serve as a baseline for project evaluation.

Plans are to bring together key stakeholders for a brainstorming session to present the project proposal, get input, and form a state leadership team. If a technical assistance request is submitted, it will be to bring in a consultant to participate in the brainstorming session, advise the leadership team, and to provide continuing education for project partners on the science linking oral health to birth outcomes and the safety of providing dental services during pregnancy. We anticipate both state and district level trainings could require technical assistance.

V. Budget Narrative

A. Expenditures

Annual Expenditures

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

Funds used for state match during federal fiscal year 2005 are from the Immunization Program. State general fund in the amount of $1,952,561 were used to purchase vaccine for children. This funding commitment allows the state to maintain universal status where all children, regardless of income or insurance status, have access to free vaccine. The other portion of MCH grant match comes from local Immunization Program funds in the amount of $569,311. These funds are used for immunization education and outreach and for conducting local immunization clinics.

The expenditures in FFY '05 that were directed to Pregnant Women including 25% of the MCH administrative budget ($44,339), Pregnancy Risk Assessment Tracking system ($60,706), 25% of the Office of Epidemiology and Food Protection MCH budget ($53,343), 20% of the Reproductive Health MCH budget ($158,876), and 25% of the Idaho CareLine MCH budget ($7,877).

Funds used in FFY '05 for Infants < 1 Year Old included 25% of the MCH administrative budget ($44,339), 25% of the Office of Epidemiology and Food Protection MCH budget ($53,343), 25% of the Idaho CareLine MCH budget ($7,877), 50% of the Immunization Program state and local funds used for block grant match ($2,521,872), provides funds to cover, newborn hearing screening ($6,764).

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($44,339), 25% of the Office of Epidemiology and Food Protection MCH budget ($53,343), 25% of the Idaho CareLine MCH budget ($7,877), 50% of the Immunization Program state and local funds used for block grant match ($1,292,806), the Oral Health Program ($389,445), and 40% of the MCH budget for Reproductive Health ($317,754).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget ($44,339), 25% of the Office of Epidemiology and Food Protection MCH budget ($53,343), 25% of the Idaho CareLine MCH budget ($7,877), the Genetics Program ($174,691) and the Children's Special Health Program ($894,121).

40% or $317,754 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age. And $317,577 in indirects was included in expenditures for the Administrative budget.

FFY '05 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget ($157,222), the Reproductive Health Program Budget ($794,383) and the Children's Special Health Program budget ($894,121). The two programs included under enabling services were the Idaho CareLine ($31,510) and 90% of the MCH money supporting the STD program. Programs included in the Population-Based Services category were Oral Health ($389,445), Immunizations ($2,585,612 - state and local match), and Newborn Hearing Screening ($6,764). Programs included under infrastructure Building Services included: MCH Administration ($177,354), Pregnancy Risk Assessment Tracking System ($60,706), Office of Epidemiology and Food Protection ($213,373), 10% of the Genetics Program ($17,469), and the indirect budget ($317,577).

Total reported MCH expenditures for Idaho during FFY '05 are $8,406,240.

B. Budget

Budget Narrative

To meet the match requirement the state will be utilizing $2,097,900 in state general fund and $444,728 in local funds.

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children and women of child bearing age, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 39% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Epidemiology.

An area we had focused additional funding on was Idaho's Pregnancy Risk Assessment Survey. Data from previous years provided an overview of perinatal issues statewide, but by increasing the sample size we are now able to identify trends in specific areas of the state. We will begin using this valuable data to guide program direction and project development.

The Lay-Midwife Project is in its second year of funding. Good strides were made by the Idaho Perinatal Project in developing the data collection tool and database. This database is used to identify the number of women with delivery complications that arrive at a hospital ER, that were first initiated with a lay-midwife. Data for the first year show that there were 23 cases spread throughout multiple hospitals in Idaho. In each case, data was collected on the mode of transportation to the hospital, stage of labor, labor history prior to arrival, maternal condition at discharge, infant condition at discharge, 5 minute APGAR, and infant weight. This has been an invaluable tool to support the need for the continuation of this project. Positive efforts have been made to collaborate on training and education with the Idaho Midwifery Council. A good working relationship continues to grow between Idaho Perinatal Project team and midwives in the state. A radio spot is currently airing that refers pregnant women to Idaho's CareLine for referrals to appropriate health care providers and to get a list of 10 questions to ask before delivery at home. Based on the results of the birth complications survey, the Project is planning to move forward with seeking legislation to ensure the best possible birth outcomes for all infants born in Idaho.

The Idaho Perinatal Oral Health project has been well received. This project will target primary care providers, dentists and other professionals in the community to increase awareness of the importance of a dental visit during the second trimester. The project will also work toward improving the awareness among females of reproductive age about the importance of dental care during pregnancy. $50,000 has been allocated to this project, and it will be administered through the oral health program. In this coming year a statewide media campaign and educational pieces will be produced.

The project that was implemented this past year increasing utilization of body mass index among pediatricians and other health care professionals caring for young children and adolescents has been completed and is currently being evaluated. The BMI project was managed by the WIC Program. This year the WIC Program is proposing a project to assist employers in becoming breastfeeding friendly by supporting mothers who are nursing. This project will be a train-the-trainer format with breastfeeding coalitions around the state in an effort to increase local level expertise. The estimated cost of the project is $30,000.

The above mentioned projects are directly intended to create systems change. This allows the federal MCH dollars to be invested for only a short period of time with long term benefits to the overall system caring for pregnant women and children.

One area that the State has made progress on over the past year is transitioning Idaho's Children's Special Health Program away from being primarily an insurance plan to focusing on care coordination for the uninsured and ensuring reasonable access to specialty care throughout the state. This is the first step to a longer term plan of ensuring access to care and health care system navigation for all families of children with special health care needs, not just those covered by Idaho's current program. In past years, expenditures in this category have always by far exceeded the amount allocated. The mechanism by which this was allowed to occur was as follows: First was utilizing unspent funds from previous grant awards, and secondly by reducing funding in other high priority MCH programs/activities. CSHP has stayed within budget but has had a very difficult time addressing billing issues. The billing issues have been addressed and CSHP is now in a good position as we move into Medicaid reform here in Idaho. Future projects will include the development of a CSHP website, program evaluation and continued work with various agencies, organizations and policy makers to develop the future role for MCH and CSHP.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.